STATE OF DELAWARE
DEPARTMENT OF CORRECTION
245 McKEE ROAD
DOVER, DELAWARE 19904
Telephone: (302) 739-5601
Fax: (302) 739-8222

Delaware Department of Correction Compliance Report

Submitted Pursuant to the Memorandum of Agreement Between the United States Department of Justice and the State of Delaware Regarding the Delores J. Baylor Women's Correctional Institution, the Delaware Correctional Center, the Howard R. Young Correctional Institution and the Sussex Correctional Institution

July 31, 2009

Department of Correction
Carl C. Danberg, Commissioner
James C. Welch, RN, HN-BC Chief, Bureau of Correctional Healthcare Services
Spencer Epps, MD, MBA, Medical Director

INTRODUCTION

This Compliance Report is submitted pursuant to the Memorandum of Agreement ("MOA") between the United States Department of Justice ("DOJ") and the State of Delaware (the "State") regarding the Delores J. Baylor Women's Correctional Institution ("BWCI"), the Delaware Correctional Center ("JTVCC")[1], the Howard R. Young Correctional Institution ("HRYCI") and the Sussex Correctional Institution ("SCI").[2] The purpose of this Compliance Report is to provide the DOJ with current information regarding the State's progress implementing the Delaware Department of Correction Action Plan dated April 30, 2007 (the "Action Plan"), and steps taken by the State to ensure compliance with each of the substantive provisions of the MOA.[3]

[1] On June 3, 2008, Delaware Governor Ruth Ann Miner signed a bill renaming the Delaware Correctional Center, the James T. Vaughn Correction Center.

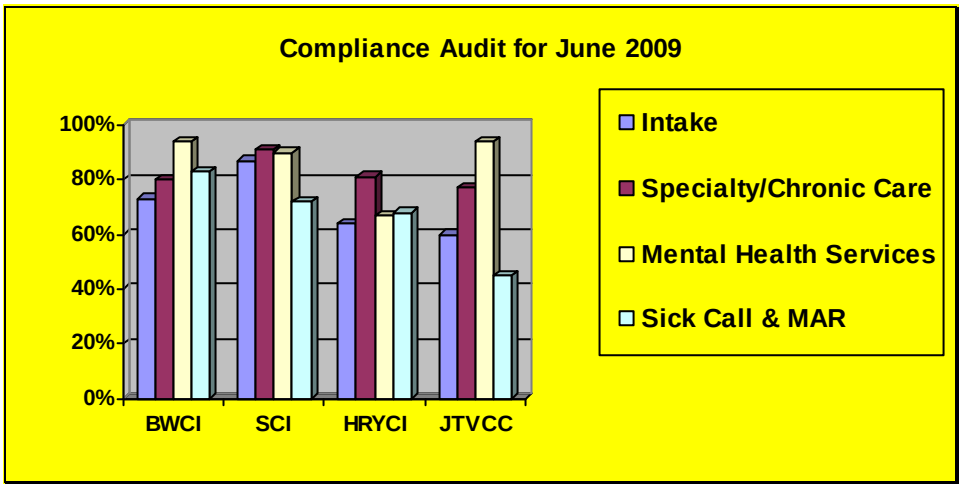
[2] Baylor, HRYCI, JTVCC, and SCI are also referred to individually as a "Facility" and collectively as the "Facilities" in this Compliance Report.

[3] This Compliance Report is prepared entirely as a result of the compromise of disputed claims brought by the United States Department of Justice against the State of Delaware. Nothing contained herein shall constitute or is intended to be interpreted as an admission of legal liability or an independent statement of fact. The statements contained herein are intended to be without prejudice to future or collateral legal actions, defenses or positions on behalf of the State of Delaware, or its agencies, departments, and employees. Additionally, the statements and documented actions by the State contained herein are subsequent remedial measures as set forth in Federal and State Rules of Evidence 407 and are taken with the express purpose to remediate any identified deficiency in the provision of services to inmates within the custody of the State of Delaware Department of Correction.

EXECUTIVE SUMMARY

Since the initiation of the Memorandum of Agreement between the State of Delaware and the US Department of Justice, DOC has invested heavily in improving its correctional health care system, despite growing scarcity of resources. DOC has restructured its Bureaus to create a Bureau of Correctional Healthcare Services (BCHS) and hired a team of highly trained clinical and administrative professionals to develop site-specific and systemic programs to improve health care services across the State. DOC has dramatically improved its receptiveness and responsiveness to public, State and Federal concerns for individual and system-wide health concerns, and through BCHS, is implementing strategies to address and prevent deficiencies in the correctional health care system. The evidence of this can be seen most clearly in the sustained improvements at two of the Facilities monitored under the MOA, BWCI and SCI. As a direct result of DOC commitment to changing its culture and its organizational structure to provide better care for its inmates, these two sites are near substantial compliance with the MOA.

The remaining two sites, JTVCC and HRYCI have seen some improvements, but have had difficulty sustaining positive changes over time. The primary reason for this has been the inability to maintain stable health services leadership at these sites. Without stable leadership, improvements are not maintained and line staff are not accountable for helping to identify and fix problems at the site level.

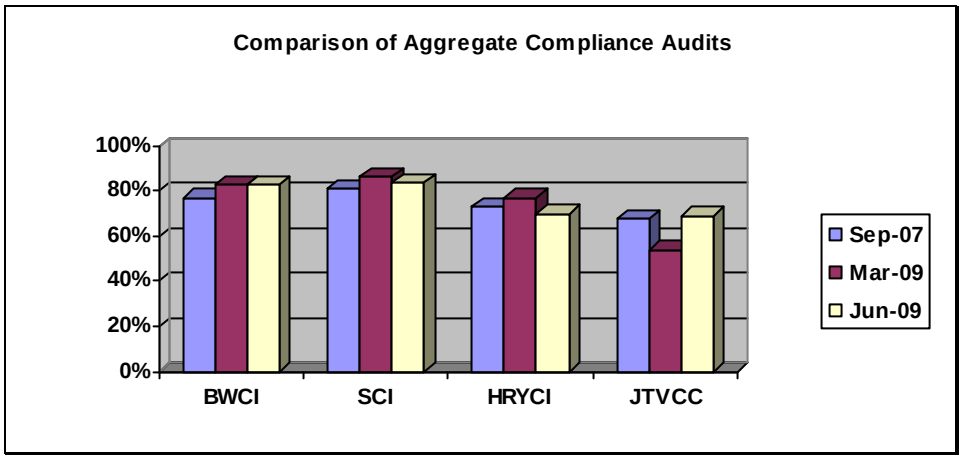


***Graph 1*:** Inability to sustain leadership in health services appears to be the primary reason for continued deficiencies at HRYCI and JTVCC. More BCHS/DOC time and resources may need to be devoted to oversight of these sites to achieve sustainable improvement.

The chart above (*Graph 1*) reflects the current status of the four Facilities covered by the MOA. Each quarter, BCHS performs an audit of the sites along four important categories: Intake, Specialty/Chronic Care, Mental Health Services, and Sick Call & Medication Administration Records (MAR). These audits are performed so that BCHS can assess the performance of its clinical services vendor, CMS, and

determine where and what type of corrective action is required to improve quality of services. Graph 1 shows that BWCI and SCI are substantially compliant or approaching substantial compliance across all four categories, while JTVCC and HRYCI continue to experience difficulty in attaining substantial compliance in a number of categories.

Graph 2 shows Facility performance on contractual audits over time. The first bar of each of the four clusters shows the contractual audit results at the beginning of the MOA. The middle bar of each of the four clusters shows the contractual audit results last quarter, and the last bar of each cluster shows the contractual audit results for this quarter.



Graph 2: DOC efforts to improve its correctional health care system can be seen in the improvement in quality of care at BWCI and SCI. Both sites have sustained these improvements over time. JTVCC and HRYCI have shown periods of improvement but have not achieved sustainability. BCHS must actively devote more of its scarce resources to developing leadership at these two Facilities.

The graph demonstrates that BWCI and SCI have shown steady and sustainable improvement since the beginning of contractual audits in 2007. HRYCI shows periods of un-sustained improvement and current problems with provision of health care services. JTVCC shows marked improvement from last quarter, but performance does not appear dramatically improved from the beginning of contractual audits in 2007.

In order for DOC to maintain the quality of care at BWCI and SCI, and achieve sustainable improvement at JTVCC and HRYCI, more BCHS time and resources must be found to devote to oversight of these Facilities.

PROGRESS

Effective July 1, 2009, the State entered into a one-year contract extension with Correctional Medical Services ("CMS") to provide medical and mental health services to the inmate population housed at all of the Department of Correction ("DOC") facilities, including the four Facilities subject to the MOA. Under the contract, CMS is required to fully staff the medical and mental health services provided to offenders housed at all DOC facilities. CMS employs a Regional Medical Director, Regional Vice President, Regional Ombudsman, Regional Manager, Regional Mental Health Director, Regional Psychiatry Director, Regional Dental Director, Regional Medical Records Supervisor and State Director of Nursing ("DON"). Further, at each Facility, CMS employs a site Health Services Administrator ("HSA") and DON to oversee the medical and mental health care provided to the inmate population. A minimum level of staffing is contractually required.

Contractual Audit Tool:

An Audit Tool was implemented under the Third Amendment to the previous service contract between CMS and DOC. This Audit Tool was approved by Dr. Ronald Shansky, Chief Medical Monitor and carried forward into the July 1, 2009 CMS contract. The Audit Tool was designed to evaluate CMS compliance with written performance standards that are based on standards established by the National Commission on Correctional Health Care ("NCCHC"), CMS protocols in effect at the time of the audit; and any policies, protocols, procedures or clinical pathways currently existing or adopted in the future by DOC. Pursuant to the service contract, audits are performed on a quarterly basis in the areas of Intake, Chronic Care, Specialty Referrals, Mental Health Services, Sick Call visits and medication administration. This audit mechanism provides for financial penalties that are imposed if CMS does not achieve specific compliance targets at a Facility. In addition, at the end of each audit period, CMS is required to submit a specific Facility Corrective Action Plan based on the audit results. This ensures that the Facility has a plan in place to address deficiencies found during the audit process and use the process to improve systems issues. The most recent contractual audit was conducted at all Facilities during the week of June 1, 2009 (the results of these audits can be seen in *Graphs 1* and *2*).

Substantial modifications and improvements to the Delaware Automated Correction System ("DACS") medical module, which are described at length in the Action Plan,[4] were implemented at all DOC facilities. Additional enhancements to DACS and medical vendor staff training are ongoing. The updated DACS medical module serves as a vital tool for ensuring compliance with medical and mental

[4] *See* the DOC Action Plan, Section 3a , *available at:* http://doc.delaware.gov/pdfs/Delaware%20DOC%20Action%20Plan.pdf

health care standards. Further, the updated DACS system allows the DOC and CMS to obtain statistical information regarding types of inmate care being provided and areas of need at each of the Facilities.

EMR:

Further, the DOC has recently completed an electronic medical records ("EMR") study. The purpose of the study is to determine what type of EMR will meet the distinct needs of medical and mental health care in a correctional setting. The team met with various members of the medical and mental health staff to discuss documentation requirements; acute and chronic health care access; work-flow optimization; monitoring and reporting requirements; compliance issues; scheduling, diagnostic and laboratory capabilities; emergent and non-emergent off-site medical management; Continuous Quality Improvement (CQI); and other issues critical to provision of health services. The contractor retained to perform the EMR study generated a suggested Request for Proposals (RFP), and this RFP will be used to solicit EMR vendors who can meet the specific needs detailed in the RFP. The DOC is hopeful that once an EMR vendor is selected, implementation of an EMR could be completed at all Facilities by mid- to late 2010. The use of an EMR is expected to eliminate the need for a paper record and assist with the continuity of care for inmates. An EMR is also expected to eliminate filing backlogs, lost charts, and the existence of multiple charts created for the same offender.

BCHS:

As is noted briefly above, the Bureau of Correctional Healthcare Services (BCHS) was created since the last Compliance Report. This Bureau is the fourth Bureau in the Department of Correction, and its creation was recommended in a health care study that was conducted and completed in 2008.

Growing Self-Auditing Capacity:

BCHS has made significant progress in its ability to audit all Facilities. In addition to the quarterly contractual audits, BCHS solicited the audit tools used by the Monitoring Team to ensure that critical areas of inquiry were comprehensively addressed in a multidisciplinary manner. The tools provided by the Monitoring Team were used to augment DOC contractual audit tools, and are now being used to conduct audits very similar to those performed by the Monitoring Team. SCI was the first site audited by BCHS with the new audit tool, in May 2009. BCHS conducted an audit of SCI prior to the Monitoring Team's arrival to the Facility, using the Monitoring Team's methodology. Results of DOC's audit were provided to the Monitoring Team at the Facility for feedback and comparison of their findings during their monitoring of the site.

DOC then conducted an audit of BWCI prior to the Monitoring Team' June 2009 site visit. DOC findings obtained by different reviewers over multiple audits produced similar results, suggesting external validity of DOC audit tools. External validity in this context means that the results of the audit tools are objective and generalizable; the findings are fair because the audit tools' measurement does not change from site to site or from auditor to auditor. The results were sealed prior to the Monitoring Team visit and were provided to counsel. The Monitoring Team then conducted their audit and presented their findings. DOC audit findings were highly convergent (approximately 90% convergent) with those of the Monitoring Team. The primary explanation for the small divergence in findings was twofold:

- **DOC sample sizes were larger:** Larger sample sizes are more sensitive to highly recurrent issues symptomatic of site-specific deficiencies, and give perspective to anecdotal events.
- **DOC compares Facilities Statewide:** Comparison of a Facility's' performance to that of all other Facilities in the State, in addition to a Facility's individual improvement, tended to make DOC findings more critical than the Monitor's findings.

Consistency of DOC findings with those of the Monitoring Team suggests external validity and growing DOC capacity to self-monitor the State correctional health care system. That DOC findings are at least as critical of the system as the Monitors' findings suggests that DOC has adopted appropriate internal standards for quality control and understands how to measure performance against those standards.

BCHS employs both quantitative and qualitative methodologies in its audit process. *Quantitative* methodology asks, "how much" or "how often" did something occur. It also allows objective observers to confirm and replicate audit results. *Qualitative* methodology gives context to measurements- in this case, it provides information on the quality of performance (no matter how many times it has occurred) and the appropriateness of interventions. Qualitative methodology also lays the foundation for root cause analysis of site-specific problems and customized approaches to solving systemic issues. Qualitative techniques included interviews with site administrative and clinical staff. This is a primary advantage of State self-auditing, particularly in correctional medicine, where individual sites can have distinct cultures. BCHS has demonstrated capacity to self-audit its correctional health care system. This achievement has been the result of BCHS's focused efforts over the past three years to progressively formalize oversight of health care delivery. This can be broken down into three distinct phases:

- **Phase I:** BCHS began by tracking and cataloguing anecdotal site-specific breaches in health care delivery.
- **Phase II:** BCHS analyzed these qualitative data to distill from recurrent issues the site-specific

and systemic deficiencies in performance; BCHS then developed focused, objective contractual audit tools to assess quality of services and performance of site staff and CMS corporate leadership.

- **Phase III:** BCHS augmented these quality-assurance metrics by soliciting and incorporating Monitoring Team tools into a multidisciplinary, rigorous process of quantitative analysis. BCHS has continued to improve its monitoring rubrics by increasing sample sizes to ensure external validity, and by refining auditing tools for internal validity of assessments.

PROCESS

As DOC's capacity to self-audit evolves so will the structure of its compliance reports. This report demonstrates this evolution. SCI and HRYCI findings reflect previous contractual DOC audit methodology; BWCI and JTVCC findings reflect the new, comprehensive audit methodology.[5] In subsequent compliance reports, all site findings will reflect the comprehensive audit methodology.

In brief, contractual audit findings measure whether or not a metric is present. MOA-style audits also measure the quality of a metric. A contractual audit was done for all sites: 240 charts were audited for JTVCC, 310 charts were audited for HRYCI, 150 charts were audited for BWCI, and 265 charts were audited for SCI. MOA-style audits required review of charts in addition to the charts reviewed for the contractual audits. The sample sizes of the MOA-style aspects of the comprehensive audits ranged widely, depending on the metric evaluated and the universe of charts containing the metric.

[5] I.e., the contractual audit tool augmented by audit tools provided by the Monitoring Team.

MEDICAL AND MENTAL HEALTH CARE

(1) Standard:

DOC continues to strive for compliance with each substantive standard set forth in the MOA. BCHS and CMS meet weekly to address problem areas and establish timelines and plans for addressing these concerns. Additionally, BCHS solicited advice from experts and consultants when needed. For example:

- BCHS worked closely with the Monitoring Team experts to draft and revise any additional policies and procedures as necessary. The Monitoring Team also provided advice and instruction on self-monitoring techniques, methodologies and processes.
- The Delaware Department of Health and Social Services ("DHSS"), Division of Public Health ("DPH") was consulted regarding immunization and communicable disease reporting practices. In addition, DOC has been working with DPH on obtaining and administering hepatitis and influenza immunizations. Both immunizations are offered to correctional staff and the offender population.
- BCHS is also working with DPH regarding possible HIV, syphilis, gonorrhea and chlamydia testing of offenders. Currently, syphilis testing is being conducted at Baylor Women's Correctional Institution. Additional testing will be targeted to those offenders who are at high risk of contracting such diseases.
- BCHS worked with the Delaware Division of Substance Abuse and Mental Health to develop protocols for providing methadone maintenance to pregnant opiate addicts incarcerated in a DOC Facility, in accordance with MOA requirements.
- BCHS consulted with the DHSS, Office of the Medical Examiner ("OME") regarding autopsies and medical file reviews of all offenders whose death occurs while in DOC custody. OME is conducting full autopsies for any inmate death that occurs while the inmate is in custody.

(2) Policies and Procedures:

On November 19, 2007, the DOC implemented its health care policies under Chapter 11, Health Services of the DOC policy manual.[6] In addition, DOC has just completed updating the policy manual to reflect and incorporate the latest NCCHC protocols, Monitoring Team recommendations, and any necessary revisions. During the 2009 site visits, site-specific procedures for all Facilities covered by the MOA were provided to the Monitoring Team. At each site, the Monitoring Team reviewed the procedures and gave suggestions for edits and additional procedures. The Monitoring Team's comments were implemented

[6] The DOC Health Services policies are available at http://www.doc.delaware.gov/ (see Chapter 11).

into the site-specific procedures and all revised versions were sent to the BCHS and the Facility for implementation. When necessary, the DOC has also solicited the views of DOJ experts on correctional health care policies and procedures.

(3) Record Keeping:

(a) As noted above, the DACS updated medical module was implemented in 2007. Enhancements to the medical module were made in the areas of intake screening, appointment scheduling, medical transfers, chronic care, sick call, outside consult tracking, tracking care provided to pregnant offenders, mental health care, administrative segregation, dental care, and general reporting functions. CMS has established a policy that designated staff members are to be assigned "Super User" status for training purposes. The "Super User" is responsible for providing ongoing DACS training to medical and mental health staff at each Facility. Further, CMS has established DACS training as part of its new employee orientation process to ensure the staff is aware of the DACS functions available and able to use DACS effectively before starting employment at a DOC Facility. Additional enhancements to DACS have been implemented and periodic upgrades and improvements to DACS are anticipated.

(b) As previously noted, CMS now employs a Regional Medical Records Supervisor. The Supervisor has been to all Facilities to provide training, ensure medical records are current, and assist with the archiving process. The BCHS and the Regional Medical Records Supervisor continue to work collaboratively to ensure that medical records are uniform at all Facilities and implement any suggestions made by the Monitoring Team. All Facilities use a unified record. As of July 31, 2009, CMS reports that all Facility medical records positions required under the DOC-CMS contract are currently staffed.

BWCI:

Record Keeping at BWCI is improving, however deficiencies remain. Documentation of rational for patient management is of particular concern, as is documentation of discussion of treatment plan or lab results (especially normal results) with patients. MARs were backlogged one to two months in terms of being filed in the patient record. Critical information on blood sugar checks for diabetic patients was kept in a paper log manual in the infirmary without concomitant information in the medical record. Pregnancy testing was also an issue; on at least two occasions, DOC auditors identified patients with negative pregnancy tests with a handwritten comment reading "test kit not available". BCHS worked with the CMS site leadership to assure that pregnancy test kits are available.

JTVCC:

Record keeping at JTVCC continues to improve; however, the system in place for ensuring laboratory reports be filed in charts is problematic. Additionally, the audit revealed a problem assuring that the provider reviews results. BCHS is working with site leadership to assure that post orders identify the specific individual responsible for collecting laboratory results and presenting the results to the provider for review (see MOA paragraph 4 below, *Medication and Laboratory Orders*).

Record keeping issues related to specific MOA paragraphs are described below in detail.

(4) Medication and Laboratory Orders:

DOC policy requires that Facility medical staff ensure timely responses to medication orders and laboratory tests. Practitioners have access through a secured Internet portal to view lab results from the laboratory services vendor. Use of logs to track timeliness and ensure labs are being properly followed has been encouraged at all Facilities. Facility-specific issues regarding transcription, implementation and follow-up are being addressed.

The Audit Tool is also being used to monitor compliance with DOC policy. Prior to the audit, offender charts selected are based on the type of psychotropic medications the offender is prescribed and the required laboratory testing that needs to be completed on a regular basis. Due to the potential side effects of psychotropic medication, the need for regular laboratory testing is crucial to ensure that offenders receiving the psychotropic medications do not develop levels of toxicity. High levels of toxicity can lead to drowsiness, cardiac conditions, coma and even death.

DOC is working with CMS to develop a new system to ensure that any laboratory reports for a Facility are reviewed by a physician and placed in the medical file immediately after review. Abnormal critical lab results are to be referred immediately to the on-call physician; abnormal labs not of a critical nature are reviewed by the physician the following day, and all other labs are reviewed by physician on a routine basis. There is to be a nurse assigned to reviewing laboratory results at every site who is responsible for collecting and triaging lab results.

BWCI:

DOC policy requires that Facility medical staff ensure timely responses to medication orders and laboratory tests. BWCI demonstrated a high rate of compliance in laboratory testing for offenders on psychotropic medications. All charts selected for the audit indicated that when an offender required

regular laboratory testing for psychotropic medications, the labs were ordered by the psychiatrist, were performed timely, and proper follow-up occurred.

Review of offender charts requiring psychotropic medications be verified and ordered within twenty-four hours of their arrival to BWCI indicated that 83% of those offenders received their medications within the required time frame. The majority of charts reviewed for timely medication re-orders indicated that medications were re-ordered and provided to the offender in a timely manner. One chart reviewed showed a medication order that was 10 days late; the patient had to put in a sick call slip to receive the appropriate medication.

Psychiatric medications were renewed in a timely manner and adjustments were made based on patient report of symptoms. Bridge orders were routinely completed, however in each of the intake records reviewed for inmates who were on non-formulary medications when they arrived, the inmates were placed on a formulary medication after being seen by the psychiatrist. It was unclear if any of these patients had been tried on these formulary medications in the past or if those attempts produced unsatisfactory therapeutic results.

The MAR was up-to-date in 75% of intakes reviewed. The time to chronic care clinic visit from initial intake was timely (occurred in under 7 days) in 36% of charts reviewed. Consults from the chronic care clinic were followed up in 92% of charts reviewed. Labs were ordered from chronic care visit, followed up on, and reported to the patient in 40% of charts reviewed.

MARs were compliant in terms of administration; completeness of orders; and date, time and signature documented, in all but one aspect. One nurse consistently failed to sign the document. 40% of MARs sampled had documentation in progress notes. 90% had date and time of transcription noted. 10% did not have time noted, and 80% were accurate. One MAR reviewed had no start date noted. One had a start date that was a day later than the order. A transcription error was noted but did not appear to cause ill effects. 80% of orders written were initiated within 24 hours. 20% of charts reviewed had no start date noted on MAR but were started within 24 hours. Issues relating to missed medications are improving, and medications are being discontinued in accordance with provider orders.

Difficulties with effectively bridging inmate's medications when they arrive at BWCI continue. A review of records for recent intakes, acknowledged by interviews with staff, indicated that inmates often go for a significant period of time before medications are resumed. Further, when the offender then receives the medications they are not the same medications they were stabilized on in the community. In addition, in

two records reviewed, the psychiatrist indicated he intended to order a particular medication on his encounter note, but never actually ordered the medication on a physician's order sheet. Therefore, the inmates never received the medication. A transcription error, not related to medication, was noted in one other record. The audit also revealed that the psychiatrist often did not sign medication consent forms.

SCI:

Contractual audits indicated offenders on psychotropic medications at SCI received timely laboratory testing 85% of the time. Audits conducted by the Mental Health Treatment Administrator also showed that while lab orders were written timely by the psychiatrist, there was a lag in the transcription of the order and some were not completed in a timely manner. Two of the charts reviewed during the audit indicated greater than a four-week delay in implementing lab orders.

HRYCI:

Contractual audits revealed that 36% of offenders on psychotropic medications at HRYCI received timely testing. As noted previously, the need for laboratory testing for offenders on psychotropic medications is crucial. BCHS has requested that the Facility initiate a corrective action plan to address the deficiency in laboratory testing.

JTVCC:

The contractual audits indicated that 83% of the offenders on psychotropic medications at JTVCC received timely laboratory testing. Pharmaceuticals are provided by a licensed pharmacy. In the pharmacy area hand washing is available, the space is adequately lit, but the area is poorly organized. There is not a system in place to provide for monthly inspections of the pharmacy areas. The pharmacy dispenses medications from approved blister packs, and other approved containers, but there is not a system in place to have strict accountability of medications. There were 243 loose tablets found in the stock drawer. Loose medications that could be identified by number or other identifying features were Atripla, Prednisone, HCTZ, Thorazine, Stelazine, Seroquel, Wellbutrin, Haldol and others. The Facility has a method for obtaining a short-term supply of medications that are not in stock; however, three instances were found where a patient had to wait for medications beyond the 24-hour period. On inspection, the medication area is secure, and there is adequate lighting and sink and alcohol sanitizer. The area is poorly organized, however, and untidy. Boxes clutter the room, and there are piles of items that need to be inventoried. There was no food items found in the medication refrigerator. These deficiencies were discussed with the site leadership and corrective action was initiated.

A pharmaceutical and therapeutics committee meets on a quarterly basis. There is a monthly report that identifies the pharmacy utilization, list of medications used by class, and a formulary list. Medication is provided to the released offender on an ad-hock basis. This deficiency was noted and corrective action initiated. Medications are administered from a centralized medication room and local policy for medication is in compliance with statewide policy and procedures. Offenders with asthma are permitted to keep inhalers in their possession as appropriate. There is no night locker at JTVCC, as there is 24-hour coverage at the site.

Narcotics are under double lock and key and are administered from individually identified blister packs. Required signatures were present, however, there were instances where a patient's medications had been discontinued, or the patient had been released, and the narcotics were still in the "narc" box and being counted. There were 15 instances of this noted. This has been corrected as of this report.

Stock drawer medications were reviewed. Sixteen blister packs of medications were found from 2008. This accounted for 430 pills, (including various medications). Thirty-eight blister packs were found that expired at the end of 2009. There were 706 medications on cards.

External medications are stored separately and there are some stock medications. Security staff is present when medications are administered and assist nurses in conducting "mouth checks" during medication administration.

(5) Job Descriptions and Licensure:

CMS reports that it continues to ensure that all staff members are appropriately licensed and credentialed. The Regional Medical Director conducts a peer review of all practitioners on a quarterly basis. Under the DOC-CMS contract, CMS is required to provide DOC with an updated certification list on a monthly basis. Once received, the BCHS Senior Fiscal Officer reviews the certification list to ensure its accuracy and request additional detail, when indicated. The BCHS also maintains routine communication with the Board of Nursing regarding licensure and other issues related to nursing scope of practice. Any issues with licensure are further addressed during the quarterly Continuous Quality Improvement meetings between CMS and BCHS. As of this writing all CMS personnel requiring licensure were currently holding a valid Delaware, or multi-state compact license.

BWCI:

Job descriptions are available for all positions. Post orders for some areas in the nursing arena continue to be fine-tuned. All staff requiring licensure were licensed.

The Clinical Supervisor for mental health staff is a licensed psychologist and the Clinical Supervisor has been conducting ongoing group supervision of all mental health staff on a weekly basis, beginning shortly after her arrival at the facility in March 2009. Group sessions are clinically focused, include case presentations, and are reported as typically taking 1 hour or more. Individual supervision is occurring on a monthly basis or more frequently as needed. Supervision is documented in a log maintained in the Clinical Supervisor's office.

JTVCC:

The Mental Health Supervisor is a licensed psychologist and has been providing continuing supervision of all mental health staff since 6/1/2009. In addition, the mental health director at JTVCC has a Doctorate in Psychology and has been helping provide the necessary supervision to the mental health staff since 8/28/2008. Supervision is conducted in the form of monthly individual sessions. Additionally, the psychiatrist participates in the weekly mental health staff meetings and provides needed assistance. Supervisions logs are maintained in the mental health director's office.

(6) Staffing:

The DOC currently employs a BCHS Bureau Chief, who oversees management of DOC health care services; a Medical Director, Mental Health Treatment Services Administrator; Substance Abuse Treatment Service Administrator; Compliance Coordinator; Quality Assurance Administrator; Administrative Assistant; Staff Clinician, Nurse Trainer/Educator and Senior Fiscal Administrative Officer in the BCHS. With the addition of the BCHS Medical Director, Staff Clinician and other personnel, the BCHS now is conducting a self-monitoring process similar to the Monitoring Team's efforts at the Facilities. During the 2009 site visits, the Medical Director trained with the Monitoring Team, becoming educated on the methodologies used and areas targeted during the audit process. The BCHS Medical Director also attended the medical director training conference organized and conducted by members of the Monitoring Team, in Seattle, Washington, during July 2009.

As was reported in the July 30, 2007 DOC Compliance Report, 39.15 new health care staff positions were approved by the Delaware DOC, representing a 20% increase in staffing, and the July 1, 2007 contract with CMS was renegotiated to fund those additional positions. The Delaware General Assembly subsequently approved the budget required to fund these new positions. The DOC has contractual remedies available for addressing staffing deficiencies under the July 1, 2007 contract with CMS, and continues to actively monitor performance in this area. CMS provides the DOC a monthly report regarding vacant positions and the recruitment efforts being made to fill the vacancies.

As of July 31, 2009, CMS reported that they were staffed at 93.71% for all DOC facilities. CMS is required to fill any vacancies with PRN, overtime or agency staffing to ensure that a full complement of staff is on site at all times. CMS indicates that its recruiting efforts are ongoing to fulfill any current or anticipated vacancies. CMS offers enhanced recruitment plans with incentives in order to bolster its efforts to obtain potential employment candidates. Further, CMS reports that it has offered enhanced orientation and cross training of current employees along with Facility specific research in order to improve staff retention.

BWCI:

Stability of Leadership at BWCI remains a concern; however, a new HSA was hired for the site and has begun working. Consistency of message and operational oversight at the site has continued to be a problem. The DOC audit found that nursing staff was inconsistent with following protocols and procedures.

There are 2.5 FTE masters prepared mental health clinician positions at BWCI; all are presently filled. Two are fulltime positions and one is a halftime position. None is licensed.

JTVCC:

JTVCC HSA, Asst. Director of Nursing (ADON), and Scheduling Administrative Assistant are resigning; the last day for the HSA is August 28, 2009; the last day for the ADON was July 17, 2009; the last day for the Scheduling Administrative Assistant was July 24, 2009. BCHS is working with CMS to replace these positions and secure leadership of medical services at JTVCC going forward. BCHS concerns raised during its audit of JTVCC, were specifically addressed with CMS in meeting at DOC headquarters on July 22, 2009. A formal corrective action plan from CMS was submitted July 24, 2009.

BCHS interviews with CMS staff cited burnout as the primary driver for high leadership turnover; BCHS requested a formal staffing plan from CMS regarding JTVCC; CMS has initiated the following action plan:

CMS Leadership	Role
Regional Vice-President	Overall program focus and support for site leadership team
Corporate HSA at Large	Acting HSA through the recruitment, selection and training of new HSA Length of assignment 6+ months. Corporate HSA at large starts beginning of August 2009
Director of Nursing	Remaining in role as DON
Regional Ombudsman	Unit Manager for the Max Unit through recruitment, selection, and training of the ADON and second shift Charge Nurse
Regional Labor Analyst	Scheduler for the facility through the recruitment, selection, and training of new Scheduler

In addition, CMS has committed to swapping out all LPNs for RNs on the max unit and adding a charge nurse. Also, the CMS cardiologist is to increase cardiology clinic by four hours per week; the Regional Medical Director is negotiating with a Family Practice Physician to provide an additional 14-16 hrs of chronic care clinic, pending licensure in Delaware.

There is one FTE licensed psychologist/clinical supervisor and one FTE mental health director who also has a Doctor of Psychology degree and is working on completing the necessary supervision hours for her licensure. The mental health team at JTVCC consists of the following:

- 7 FTE mental health clinician positions; all are filled as 7/24/2009 with the exception of two positions
- 2 Part time mental health clinician positions; one position is vacant as of 7/24/2009
- 3 FTE mental health clerk positions
- 2 FTE activity aid positions

Currently, two mental health clinicians are licensed as LPCMH and 5 mental health clinicians are working on obtaining licensure

(7) Medical and Mental Health Staff Management:

In addition to management services provided by the BCHS personnel described above, medical and mental health staff management is provided through the CMS regional office in Dover, DE. The CMS regional office staff includes a Regional Ombudsman, a Regional Medical Director, Dietician, Regional Dental Director, Regional Psychology Director, Senior Regional Administrator, Regional Director of Nursing, Regional Mental Health Director, Regional Medical Records Supervisor and Vice President of Operations.

Each site also has a Health Services Administrator (HSA), DON, site Medical Director and Mental Health Director employed to manage the health care services at that Facility. Due to the large number of offenders, JTVCC and HRYCI employ an Assistant HSA with JTVCC also employing an Assistant DON (the Assistant HSA for JTVCC runs the associated level 4 facilities but has no formal responsibilities at the level 5 site).

BWCI:

Stability of the site management has continued to be an issue at BWCI. The DON, site Medical Director and Mental Health Director positions are filled. However, since 2007, there have been at least four different employees working in the HSA role. DOC worked with CMS to ensure a proper replacement was found for the positions and efforts made for retention. The new HSA began in June and CMS has stationed corporate leadership at the site in addition to the new HSA. A licensed psychologist was added as Clinical Supervisor in March 2009. This is a new position. The Mental Health Director has continued to occupy his position since October 2007.

SCI:

At SCI, the HSA, DON, Mental Health Director and site Medical Director positions have all been filled by the same employees for over a year. The DON has submitted her resignation, and CMS will be working with BCHS to recruit an appropriate replacement. Work is ongoing to ensure that the management of these employees is effective. CMS Regional staff is providing training and mentorship to the SCI management team regarding clinical peer review, education and supervision of employees.

HRYCI:

HRYCI also has issues with stability of management staff. An HSA, Assistant HSA and Mental Health Director are currently employed. The Site Medical Director position had been vacant since October 2008; CMS hired a Site Medical Director in June. The DON position has not had stability and is currently vacant, with at least three different employees holding the DON position since 2007. DOC continues to

work with CMS to provide adequate support to the current management staff, recruit a DON and retain the Site Medical Director.

JTVCC:

JTVCC currently employs a HSA, Assistant HSA, DON, Assistant DON, site Medical Director, Mental Health Director and a Licensed Psychologist. However, retention of the JTVCC management staff has been an issue with several different employees being assigned to the DON and HSA positions since 2007. DOC continues to work with CMS to provide adequate support to the current management staff and to retain the DON and site Medical Director for continuity of operations.

(8) Medical and Mental Health Staff Training:

CMS currently provides monthly in-service training for both medical and mental health staff. In addition, all mental health professionals employed by CMS and providing services at the Facilities are trained and legally qualified to provide mental health counseling services under guidelines established by the State of Delaware. CMS has provided targeted training to the DON staff to ensure consistent processes at all Facilities. With the recent addition of the DOC Nurse Trainer, the BCHS will begin to focus on additional areas of training for the Facilities medical, mental health and security staff. Collectively with the DOC Employee Development Center ("EDC"), the Nurse Trainer will work to ensure that appropriate DOC staff is trained on medical and mental health needs of offenders. All documentation regarding training attendance, curriculum and records is kept at the DOC Administration Office and is available for the Monitoring Team's review.

BWCI:

MH training is happening as a part of the weekly supervision sessions with the staff psychologist (the other part focuses on case review). The trainings have covered a number of topics, but the most recent one focused on supervision of suicidal patents.

JTVCC:

The mental health director at JTVCC reported that all psychiatrists and mental health clinicians have completed the necessary suicide prevention training.

(9) Security Staff Training:

Please see response to numbers (28), (32) and (43).

(10) Medical Screening:

Intake nurses complete an intake medical and mental health screening form using the DACS system. DOC policies require the intake medical screening be performed within two hours of arrival at a Facility. This screening is performed by nursing staff, and includes a mental health screening. If an inmate answers "yes" to any mental health screening questions, the inmate automatically receives a referral and assessment by a mental health professional within twenty-four hours. Additionally, nurses performing intake screening also have discretion to refer offenders for a mental health assessment. DOC policy requires the intake nurse to call mental health staff immediately if he or she believes the person poses a risk to himself or others.

In addition to mental health issues, the medical screening is structured to address serious medical conditions, and to identify acute medical needs, infectious diseases, chronic conditions, physical disabilities, and potential for drug and alcohol withdrawal. Once the information is entered into DACS, the appropriate medical and mental health appointments are automatically scheduled for the offender within the required time frames. The intake screening nurse has the ability to prioritize appointments if the offender needs to be seen by a provider prior to a routine scheduled appointment. At JTVCC, intake screenings are being performed by RN staff and all other Facilities have the DON or an RN review the intake screening to ensure compliance with bridge order medications, appropriate appointments and any other issues raised at intake are fully addressed.

To ensure that all offenders receive a full and adequate intake screening, the DACS system provides monitoring reports indicating whether required intake screenings have been performed and the percentage performed within time frames required under DOC policies. These reports are available to BCHS, as well as the HSAs and DONs at each Facility, and are used by DOC and CMS to ensure compliance with DOC intake screening policies. In addition to other metrics, BCHS measures use of DACS when auditing CMS pursuant to the contract between DOC and CMS.

BWCI:

The contractual audit portion of the intake screening assessed BWCI's aggregate score as 73%. Intake assessment criteria are labeled (A) on the audit form, and include the following questions:

Intake Assessment Criterion Audit Tool	DOC Assessment of BWCI
A1. Intake screen was completed and signed by the inmate and the health care provider on day of intake.	90%
A2. PPD planted at intake and read within 72 hours.	65%
A3. Patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred).	0%
A4. Physical examination completed within 7 days for Prison and 14 days for Jail; within 7 days for all inmates identified at intake with chronic illness.	67%
A5. Physical examination addresses issues identified at intake.	91%
A6. Pregnancy test performed at intake or refusal was signed by the inmate.	100%
A7. For pregnant inmates, the clinical plan includes management by specialty OB/Gyn provider.	100%
TOTAL SCORE INTAKE (A)	**73%**

Table 1

Failure to show that patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred) yielded a score of zero (0%) for question A-3. This dramatically lowers BWCI's overall intake score because each question is equally weighted, although the number of PPD positive patients is a small subset of the sample.

In addition to the contractual audit, DOC assessed chronic care intakes using the MOA monitor tools. There were 589 intakes at BWCI between 3/1/09 and 6/1/09. In our sample, initial intake was generally

timely (87% timely for the DOC standard, which is under 2 hours; and greater than 90% timely for the Federal Standard, which is under 4 hours) except one that was done within 4.5 hours. One patient was not able to complete intake initially, because she was combative- this led to a two-week delay in completing the initial intake. One Chronic Care Clinic ("CCC") assessment was not on the appropriate initial baseline chronic care form (the simple, chronic care update form was used when patient had not been seen in CCC in over a year). An RN signature was present on the intake form 93% of the time. In our sample, 85% of intake physical examinations were completed within the appropriate timeframe.

A progress note was present in 93% of charts reviewed. Vital signs were noted in the progress notes of 67% of charts reviewed. The quality of the progress notes was 60% (i.e., 60% were accurate, included vital signs with appropriate management, and were integrative of intake and lab information). The Health Assessment Form was appropriately used in 100% of charts reviewed (charts referring directly to Chronic Care Initial Baseline form were considered "non-applicable"). The MAR was up to date in 75% of charts reviewed. The time to chronic care clinic visit from initial intake was timely (happened in under 7 days) in 36% of charts reviewed. Consults from chronic care clinic were followed up on in 92% of charts reviewed. Labs were ordered from chronic care visit, followed up on, and reported to the patient in 40% of charts reviewed.

SCI:

The contractual intake audit assessed SCI with an aggregate score of 84%.

Intake Assessment Criterion Audit Tool	DOC Assessment of SCI
A1. Intake screen was completed and signed by the inmate and the health care provider on day of intake.	100%
A2. PPD planted at intake and read within 72 hours.	96%
A3. Patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred).	75%
A4. Physical examination completed within 7 days for Prison and 14 days for Jail; within 7 days for all inmates identified at intake with chronic illness.	84%
A5. Physical examination addresses issues identified at intake.	82%
A6. Pregnancy test performed at intake or refusal was signed by the inmate.	N/A
A7. For pregnant inmates, the clinical plan includes management by specialty OB/Gyn provider.	N/A
TOTAL SCORE INTAKE (A)	**84%**

Table 2

A recent review of the intake screening process indicated that over 90% of the intake screenings were being performed within two hours of the offender's arrival to SCI pursuant to DOC policy. Audits performed by the DOC Medical Director also noted that many of the screenings contained detailed progress notes.

HRYCI:

The contractual intake audit assessed HRYCI with an aggregate score of 64%.

Intake Assessment Criterion Audit Tool	DOC Assessment of HRYCI
A1. Intake screen was completed and signed by the inmate and the health care provider on day of intake.	94%
A2. PPD planted at intake and read within 72 hours.	62%
A3. Patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred).	0%
A4. Physical examination completed within 7 days for Prison and 14 days for Jail; within 7 days for all inmates identified at intake with chronic illness.	76%
A5. Physical examination addresses issues identified at intake.	86%
A6. Pregnancy test performed at intake or refusal was signed by the inmate.	N/A
A7. For pregnant inmates, the clinical plan includes management by specialty OB/Gyn provider.	N/A
TOTAL SCORE INTAKE (A)	**64%**

Table 3

Failure to show that patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred) yielded a score of zero (0%) for question A-3. This dramatically lowers HRYCI's overall intake score because each question is equally weighted, although the number of PPD positive patients is a small subset of the sample.

JTVCC:

Overall intake for DOC's contractual audit of JTVCC was assessed as 60%.

Intake Assessment Criterion Audit Tool	DOC Assessment of JTVCC
A1. Intake screen was completed and signed by the inmate and the health care provider on day of intake.	98%
A2. PPD planted at intake and read within 72 hours.	83%
A3. Patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred).	0%
A4. Physical examination completed within 7 days for Prison and 14 days for Jail; within 7 days for all inmates identified at intake with chronic illness.	18%
A5. Physical examination addresses issues identified at intake.	100%
A6. Pregnancy test performed at intake or refusal was signed by the inmate.	N/A
A7. For pregnant inmates, the clinical plan includes management by specialty OB/Gyn provider.	N/A
TOTAL SCORE INTAKE (A)	**60%**

Table 4

Again, failure to show that patients with positive PPDs are evaluated within 2 weeks (CXR performed and visit with provider occurred) yielded a score of zero (0%) for question A-3. This dramatically lowers JTVCC's overall intake score because each question is equally weighted, although the number of PPD positive patients is a small subset of the sample.

Another area that was discovered to be a problem at JTVCC was offenders who had "late" intakes completed. To address this issue the DON has been assigned responsibility for generating and reviewing daily DACS reports that identify any offender who has not had an intake screen completed.

In addition to the contractual audit, DOC assessed chronic care intakes at JTVCC using the MOA monitor tools. The intake period was from 3/1/09 and 6/1/09. In our sample, initial intake of chronic care patients was 100% timely (under two hours for DOC standard; under 4 hours for MOA monitor standard). An RN signature was present in 83% of charts reviewed. Quality of the intake screen itself was high (all questions were answered, narrative detail was present on all positive responses, and vital signs were noted) in 94% of charts reviewed. While a progress note was present 94% of the time, the quality of the progress note was found to be high in 56% of charts reviewed. PPDs were placed and read in the appropriate timeframe in 100% of charts reviewed. While the health assessment form was present in 88% of cases, in most cases (70%) the form simply referred to the chronic care initial baseline form.[7] Vital signs were noted in 50% of charts reviewed.

Discharge Planning at all Facilities:

At all DOC Facilities, discharge planning begins at intake. Currently, each site HSA is responsible for using the DACS system to generate reports on any offenders scheduled for release within thirty days. The HSA forwards the list of imminent releases to the appropriate medical, mental health and dental disciplines for discharge and after-care planning. Discharge planning is performed for offenders with serious medical or mental health issues, and a record of the plan is maintained in the offender's medical record. Pursuant to DOC policy, offenders who have been incarcerated in a DOC facility for at least 30 days (and have a chronic care condition or are prescribed psychotropic medication) will receive a 30-day supply of medication upon their release. Each Facility is responsible for maintaining logs and documenting discharge planning for both medical and mental health patients. Further, the Facility Infection Control Nurse ("ICN") has attended specialized training for discharge planning, and is responsible for all discharge planning for offenders with HIV diagnoses. The Facility ICN is also responsible for reporting all HIV discharge planning to BCHS on a monthly basis to ensure proper planning is being completed for released offenders with HIV diagnoses. CMS and the DOC continue to work collaboratively to ensure proper tracking of released offenders is completed so inmates are released with appropriate medications, appointments and any other assistance needed upon release.

Reportable results are reported to the Division of Public Health ("DPH") for all offenders; all efforts are made to contact released offenders to discuss reportable laboratory results and to ensure proper follow-up and care.

[7] This raises questions about the utility of the form and whether there is an opportunity to streamline the intake documentation process for clinical staff. Conversion to EMR will likely solve this problem.

(11) Privacy:

Please see response to (18).

(12) Health Assessments:

According to DOC policy, a health assessment is performed within seven days of an offender's arrival at a Facility. When the intake process is completed, DACS automatically schedules appointments for the inmate's health assessment and tuberculosis skin test checks (if applicable), as well as appointments to address any mental health, chronic care, or other significant health care needs identified during intake. Further, once the initial health assessment is completed, DACS automatically schedules all follow up periodic health assessment appointments. Pursuant to DOC policy, a chronic care patient will be assessed based on level of acuity, but at least annually, while offenders less than 40 years of age are to have a periodic health assessment every five years. Offenders over 40 years of age are to have a periodic health assessment every other year.

Under NCCHC standards and DOC policies, any offender who was previously incarcerated in a Delaware DOC Facility and received a health assessment within the previous twelve months now receives an intake screening, as well as a chart review performed by medical staff. If the chart review and intake screening do not indicate any change in the offender's health status from the prior health assessment, a new full health assessment is not required. The offender will attend an abbreviated initial physical appointment with a provider to see if there are any issues that the inmate would like to discuss since his last physical. The notes of the appointment are maintained in the Progress Notes portion of the unified medical record to document that the appointment occurred and any issues were discussed with the offender. Monitoring reports generated by DACS are available to BCHS, HSAs and DONs to ensure compliance with the time frames established under this policy and to track health assessments.

BWCI:

The most recent round of contractual audits (*Table 1*) indicated that only 67% of the health assessments were being performed within DOC policy guidelines of seven days from the date of the offender's arrival to the Facility. When the health assessment was performed, however, the provider addressed the issues the offender raised during the intake screening process.

SCI:

At SCI, offenders received timely health assessments in 84% of the charts reviewed for the most recent round of contractual audits (*Table 2*). Although the timeliness of the health assessment itself was within the DOC policy, there were cases in which the provider failed to indicate a review of the intake screening

had even taken place. In some instances, the provider indicated that the offender had a "well check" visit, but at intake the offender indicated he had a chronic disease. No mention of the chronic disease was noted on the health assessment form to see if the provider had inquired about the disease.

HRYCI:

76% of offenders received a timely health assessment screening at HRYCI, during the most recent round of contractual audits (*Table 3*). Generally, when the health assessment was performed, the provider noted issues on the health assessment form that the offender raised during the intake screening.

JTVCC:

Health assessment timeliness was problematic for offenders at JTVCC. The most recent round of contractual audits (*Table 4*) revealed that 18% of charts reviewed had the health assessment performed within the required seven day time frame. However, when the assessment was eventually performed, the provider addressed issues raised at intake on the health assessment form by also making direct notations on the intake screening form itself. BCHS is currently investigating how to streamline the health assessment process so that adequate information can be captured efficiently.

(13) Referrals for Specialty Care:

DOC policies require referrals for specialty care to be completed within 40 days of the initial referral date. For routine requests with wait times exceeding 30 days, the patient is to be seen by the primary care physician at 30-day intervals. If the primary physician believes that the clinical presentation warrants more expeditious scheduling of the appointment, the Regional Medical Director is contacted and is responsible for assuring that necessary arrangements are made. The efforts to expedite the appointment are documented in the progress note. DOC policy requires follow-up requests be scheduled in accordance with the outside consultant's recommendations unless the primary care practitioner documents an alternative plan in the medical record.

In March 2008, CMS implemented a policy requiring follow-up forms to be used at all Facilities to assist in tracking offender care upon return from an outside consult. Continual training on use of the nursing form is being provided at all Facilities. Beginning January 2009, a statewide consult tracking form is being used at all Facilities to ensure uniform and consistent tracking. Further, the DOC Audit Tool provides for quarterly monitoring of this process to ensure compliance. Any failure to adhere to DOC policy may result in the imposition of contractual penalties on CMS.

Specialty care referrals are also being monitored through the Facility quality assurance process and monthly reporting of specialty care logs by the Facility HSA; BCHS reviews these reports to ensure compliance with DOC policy. The specialty care consult reports are required under the DOC contract with CMS and are generated monthly. The same specialty care consult reports are also produced by CMS for analysis and discussion at monthly Medical Audit Committee ("MAC") meetings, and the upgraded DACS system has also enhanced DOC's ability to track outside consults. Problems and delays identified through these efforts are addressed on an ongoing basis by CMS and BCHS staff.

BWCI:

Although the timeframe for the referral process was timely in all charts reviewed with corresponding documentation from the offsite provider in 90% of charts, half (50%) failed to have the proper nursing form filled out upon the patient's return to BWCI. In addition, provider documentation was present indicating the results were reviewed with the offender and a treatment plan was discussed in 70% of charts reviewed.

Specialty Care & Chronic Care Assessment Criterion Audit Tool	**DOC Assessment of BWCI**
B1. Timeframe from provider order to patient off-site visit is no more than 60 days; a provider will re-evaluate the patient.	100%
B2. When patient is returned from off-site visit there is documentation from specialty provider or notation from site provider noting TX recommendations.	90%
B3. Upon return from outside specialty appointment, the patient is seen by nurse at the facility.	50%
B4. Patient is seen on-site by provider within 7 days of being seen for off-site specialty care, and treatment plan is noted.	70%
B5. The chronic care patient is seen every 3 months or more frequently as determined by the provider; provider's plan includes appropriate diagnostic & therapeutic intervention.	65%
B6. Chronic care visit is noted on CC flow sheet and includes education and follow up.	75%
B7. Patient with chronic care disease is enrolled in related chronic care clinic.	95%
B8. Problem list is updated.	95%
TOTAL SCORE SPECIALTY/CHRONIC CARE (B)	**80%**

Table 5

SCI:

The most recent contractual audit showed that the process of requesting an outside referral was timely in 95% of the charts reviewed. Further, all charts had the documentation from the specialty provider in the chart and there were notes from the site provider indicating that the results and treatment plan were discussed with the offender.

Specialty Care & Chronic Care Assessment Criterion Audit Tool	DOC Assessment of SCI
B1. Timeframe from provider order to patient off-site visit is no more than 60 days; a provider will re-evaluate the patient.	95%
B2. When patient is returned from off-site visit there is documentation from specialty provider or notation from site provider noting TX recommendations.	100%
B3. Upon return from outside specialty appointment, the patient is seen by nurse at the facility.	100%
B4. Patient is seen on-site by provider within 7 days of being seen for off-site specialty care, and treatment plan is noted.	75%
B5. The chronic care patient is seen every 3 months or more frequently as determined by the provider; provider's plan includes appropriate diagnostic & therapeutic intervention.	92%
B6. Chronic care visit is noted on CC flow sheet and includes education and follow up.	70%
B7. Patient with chronic care disease is enrolled in related chronic care clinic.	100%
B8. Problem list is updated.	94%
TOTAL SCORE SPECIALTY/CHRONIC CARE (B)	**90%**

Table 6

HRYCI:

Generally, the offsite process was timely at HRYCI, a finding that was supported by the most recent contractual audit. The referral was timely with all but one chart containing the offsite provider's notes. Further, the nursing form accompanied the chart indicating the offender had been seen upon his return to HRYCI. However, while the form was in the chart, it was often incomplete. Some forms were missing vital sign information while others failed to indicate which housing the offender was placed in upon his return.

Specialty Care & Chronic Care Assessment Criterion Audit Tool	DOC Assessment of HRYCI
B1. Timeframe from provider order to patient off-site visit is no more than 60 days; a provider will re-evaluate the patient.	100%
B2. When patient is returned from off-site visit there is documentation from specialty provider or notation from site provider noting TX recommendations.	89%
B3. Upon return from outside specialty appointment, the patient is seen by nurse at the facility.	89%
B4. Patient is seen on-site by provider within 7 days of being seen for off-site specialty care, and treatment plan is noted.	75%
B5. The chronic care patient is seen every 3 months or more frequently as determined by the provider; provider's plan includes appropriate diagnostic & therapeutic intervention.	52%
B6. Chronic care visit is noted on CC flow sheet and includes education and follow up.	74%
B7. Patient with chronic care disease is enrolled in related chronic care clinic.	90%
B8. Problem list is updated.	82%
TOTAL SCORE SPECIALTY/CHRONIC CARE (B)	**81%**

Table 7

JTVCC:

In the charts reviewed for Specialty and Chronic Care (SCC) the most recent contractual audit at JTVCC, the referral process was shown to be timely with offsite provider documentation accompanying the chart. 45% of those offenders had proper nursing return forms or notes in the chart indicating they were seen by the nurse upon their return to JTVCC. At times there were progress notes indicating the nurse may have seen the offender, but no mention of vital signs being taken, which is a requirement of the nursing offsite return form. 65% of the offender charts had provider documentation within seven days of the offender's return to the site and most of the notes indicated the results were reviewed. Very few of the provider notes indicated that the results and treatment plan were actually discussed with the offender. BCHS has authorized CMS to conduct a pilot study at JTVCC to identify underlying problems in the consult process and to determine how best to improve it.

Specialty Care & Chronic Care Assessment Criterion Audit Tool	**DOC Assessment of JTVCC**
B1. Timeframe from provider order to patient off-site visit is no more than 60 days; a provider will re-evaluate the patient.	100%
B2. When patient is returned from off-site visit there is documentation from specialty provider or notation from site provider noting TX recommendations.	95%
B3. Upon return from outside specialty appointment, the patient is seen by nurse at the facility.	45%
B4. Patient is seen on-site by provider within 7 days of being seen for off-site specialty care, and treatment plan is noted.	65%
B5. The chronic care patient is seen every 3 months or more frequently as determined by the provider; provider's plan includes appropriate diagnostic & therapeutic intervention.	78%
B6. Chronic care visit is noted on CC flow sheet and includes education and follow up.	48%
B7. Patient with chronic care disease is enrolled in related chronic care clinic.	98%
B8. Problem list is updated.	84%
TOTAL SCORE SPECIALTY/CHRONIC CARE (B)	**77%**

Table 8

Additional records were reviewed for this specific aspect of JTVCC's MOA-style audit; the findings of this audit corroborated those of the contractual audit and provided additional detail. The health record contained a Consultation Request Form and the clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form in 90% of charts reviewed. The clinician legibly documented the history of present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form in 90% of charts reviewed. The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes in 50% of charts reviewed. The record reflects that the patient was seen by the consultant within the required time frames in 80% of charts reviewed. Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations in 44% of charts reviewed (compared to 45% in contractual audit, above). The clinician reviewed, dated, and initialed the consultation report within 3 business days of the inmate's return to the facility or receipt of the report in 56% of charts reviewed. The record shows that the clinician met with the patient within five business days, (sooner if clinically indicated) to review the findings and recommendations with the patient and develop a treatment plan in 33% of charts reviewed. The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for not implementing the recommendations was documented (i.e., patient is out to court, refused, etc.), and if the physician disagreed with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented in 89% of charts reviewed. The health record reflected that the clinician monitored the patient to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended, in 75% of charts reviewed. In one chart, a colonoscopy was ordered 10/28/09 but the auditor was unable to locate any record of its being done. Pending podiatry and neurology consults were found.

(14) Treatment or Accommodation Plans:

Offenders with complex medical conditions whose management is complicated by a mental health issue, or those patients with extreme or complex mental health pictures are classified as Special Needs patients. A multidisciplinary committee comprised of members of BCHS, Facility medical and mental health staff along with Facility security staff meets at least monthly to discuss the offenders' medical issues, strategies for dealing with the issues, outcomes to achieve goals and plans of action on how to achieve those goals. Notes from the meetings are documented in the offender's medical record and updated monthly.

Special needs management has been redefined at all sites by BCHS to ensure special needs patients are identified per the definition given above, and that these patients receive optimal, methodological care. Special needs patients at all Facilities now require the following:

- Enrollment criteria: The enrollment criteria for special needs at all sites throughout the State is defined as a patient having clinically complicated medical management exacerbated by a mental health component; or, a complicated mental health picture (usually including crisis events such as attempted suicide, suicidal ideation, or other enrollment criteria for PCO status)
- Progress metrics: Clinically reasonable, and objectively measurable, goals for multidisciplinary management of enrollment condition (criterion)
- Defined exit criteria: Optimal progress of clinical goals, as measured by defined progress metrics, is determined for each enrollee; patients reaching defined clinical goals are removed from the special needs roster. Patients are re-enrolled on the special needs roster if their progress is not sustained or if their condition otherwise merits re-enrollment.

The Special Needs Committee at each Facility is multidisciplinary. Committee meetings are chaired monthly by the BCHS Medical Director at all sites, except SCI, which is chaired by the BCHS Nurse Trainer.

(15) Drug and Alcohol Withdrawal:

DOC policy provides that offenders experiencing either life threatening intoxication or withdrawal are sent to the appropriate setting to address their condition, up to and including an acute care facility, as clinically indicated. Additionally, the CMS Regional Medical Director, in coordination with the BCHS Medical Director, and in response to recommendations from the Monitoring Team, has revised the nursing protocols for alcohol and drug withdrawal. Training was provided to the medical staff on the updated protocols, and the new protocols have been implemented at all Facilities. Under the MOA, methadone maintenance is offered to pregnant offenders who are addicted to opiates or participating in a methadone maintenance program when they enter a Facility.

DOC has made arrangements for methadone maintenance to be provided through a State-approved methadone clinic for pregnant offenders who have been identified as candidates for methadone maintenance since the MOA went into effect. DOC is also currently working with the Delaware Division of Substance Abuse and Mental Health to develop protocols for methadone maintenance during pregnancy and notes that a specialist managing an addicted offender's pregnancy may conclude that methadone maintenance is contraindicated in some circumstances. DOC anticipates that if this occurs, methadone would be used to manage the pregnant inmate's withdrawal from opiates under the direction of an appropriate specialist.

There are currently two pregnant patients at BWCI on methadone; chart review showed that patients were receiving methadone treatment; however, the one to two month lag in filing MARs in charts does not reflect methadone administration for the month of July.

Chart review shows that Facilities appropriately enroll patients who self-report substance abuse issues predisposing them to withdrawal (e.g., opiate abuse, alcohol abuse) in the withdrawal protocol (CIWA). Execution of the protocol, however, continues to be deficient in terms of physician orders for enrollment in the protocol and consistent documentation of patient evaluation at each shift. In samples from all Facilities, few charts had consistent documentation of patient evaluation at every shift (i.e., there were not three CIWA evaluations filed each day). A physician order for enrollment in the CIWA protocol was inconsistent, with one site (BWCI) not requiring a physician order for enrollment (i.e., there was a standing order for enrollment of patients suffering from substance abuse issues) and the other sites having no clear policy on whether or not a physician order was required for enrollment (and, consequently, inconsistency in whether or not a physician order could be found in the charts of CIWA-enrolled patients). There was anecdotal evidence that doctors were not always called when patients were found to have high CIWA scores (indicative of symptoms of withdrawal), however, an MD was notified in the majority of cases and nursing protocols are in place for management of symptoms.

(16) Pregnant Offenders:

There are fewer than 20 pregnant inmates in the Delaware Correctional System at this time. All women housed in a level 5 facility are at BWCI.

As of the date of this report, CMS was providing obstetrics care and treatment for all pregnant females. During the intake screening, all females receive a urine pregnancy test. Any female with a positive pregnancy test result is placed on the pregnancy log, receives prenatal vitamins, and is managed by the Facility's OB/Gyn provider. The obstetrician holds clinic at BWCI weekly, and pregnant offenders are seen routinely as clinically indicated.

Pregnant inmates with HIV disease are also seen by an HIV specialist, who coordinates care with the OB/Gyn practitioner. This coordination helps to assure that appropriate medications are given to prevent perinatal transmission of HIV. Compliance with this policy is monitored on a quarterly basis through the DOC-CMS contractual audits.

(17) Communicable and Infectious Disease Management:

CMS employs Infection Control Coordinators at all of the Facilities. DOC policy and State DPH regulations establish specific guidelines regarding the type of monitoring that must be conducted for certain types of infectious disease. Offenders with communicable diseases are tracked and monitored by BCHS and the Facility Infection Control Coordinator using information collected in DACS through the intake screening, health assessment, and other relevant databases to ensure compliance with MOA and DOC standards. Monthly reports are sent to BCHS by CMS for analysis, and communicable disease reports are provided to the DPH as required. CMS reports that it has also re-structured its HIV and hepatitis C management programs in an effort to provide improved offender care from initial enrollment into the program through release from DOC. This includes additional training for infectious disease nurses and practitioners, offender dietary consultation, and offender mental health intervention. All communicable and infectious disease statistics are available for review at each Facility by the Monitoring Team.

Air flow in respiratory isolation rooms was recently tested at all Facilities, and all Facilities passed.

The BCHS Medical Director is working with CMS to target improvement in Infectious Disease (ID) care; CMS ID physicians have drafted new algorithms for managing hepatitis and HIV; the BCHS Medical Director and CMS providers are to give input toward establishing community standards. All CMS providers are to be trained on final algorithms and standards at the August CMS meeting. This process will be repeated with all chronic care conditions in an effort to improve of care for chronically ill offenders statewide.

BCHS has developed and put in place at all Facilities a terminal cleaning policy to decontaminate areas where offenders with communicable diseases have been housed; this is to prevent infection of other offenders. The BCHS Nurse Trainer also represents DOC on the Delaware Hospital Acquired Infection Advisory Committee

BWCI:

During the most recent audit of the intake process, it was noted that 65% of the PPDs planted upon intake were read within the 72 hour required time frame (*Table 1*). During the three months prior to the audit, one offender had a positive PPD test, but the required chest x-ray and provider visit did not occur within 2 weeks per DOC policy.

There is a comprehensive Infection Control ("IC") Manual, last signature date 10/2008. There is an Infection Control Nurse who appears to have a good grasp of responsibilities. In general, more orientation is required for all IC nurses to their roles, however, the BWCI IC nurse did spend two weeks with the Infection Control Nurse at HRYCI. The IC nurse works with a binder system, as well as Excel spreadsheets for maintaining documentation and forms and triaging ID cases by acuity for the CMS ID consultant. There is as binder for reportable diseases with copies of reporting sheet and lab reports.

Exposure Control plans are included in the Infection Control Manual. The IC nurse reports she has worked closely with the inmate responsible for cleaning the medical area to ensure cleaning is comprehensive. Sharps containers are readily available in appropriate areas. Hand wash facilities are readily available; however, there has been a problem with inmates removing antibacterial soap from the areas accessible to them. The eye wash station is functional, there is a log of monthly testing, and training was recently provided to staff on the eye wash station. Specimen containers are used appropriately. Biohazard storage bins are available, however, there is an inadequate supply and more have been ordered. Spills are cleaned appropriately.

There have been incidents where food and water were stored in the refrigerator with specimens. The IC nurse has been in position since March 2009, since that time she has attended one infection control meeting with IC nurses from other facilities. The IC nurse at BWCI is unsure of the frequency of IC meetings, and unsure of agendas at IC meetings, as she has only attended one.

The IC nurse reports there are test strips that can be used to test negative pressure rooms but she has found them ineffective. The IC nurse is in the process of fit testing N95 respirators for all staff. Her plan is to place each employee's mask in a zip lock bag labeled with their name. All masks will be stored in one location. She has met with limited success in convincing BWCI staff to be fit-tested.

Comprehensive binders and Excel spreadsheets are maintained for referrals to IC nurse with outcomes noted. A comprehensive log is kept on inmates with hepatitis. The IC nurse reports the standard hepatitis protocol has been treatment is initiated only if the inmate sentence is greater than 18 months, lab work

shows elevated enzymes or the inmate is symptomatic. The provider determines who is triaged to the CMS ID consultant, who handles hepatitis treatment and HIV treatment failure.

The IC nurse has begun using the accelerated protocol for providing hepatitis vaccinations to inmates who are scheduled for minimal incarceration time. HIV discharge planning is attempted, but in need of improvement. The IC nurse has created a 'care package' she sends out with inmate. She faxes a discharge form to BCHS, per policy.

Continued monitoring is necessary to ensure IC meetings are being held quarterly and that agenda items are appropriate. The IC nurse must continue to ensure staff is made aware of proper storage of food and drink away from potentially infectious materials

SCI:

The tracking process at SCI for PPD plants and follow up reads was significantly better than the other three Facilities. 96% of the offenders had their PPD plants read within the 72-hour time frame (*Table 2*). Further, 3 out of the 4 positive PPD reactors had their chest x-rays and provider visits noted in the chart within 2 weeks of their positive PPD read.

HRYCI:

HRYCI also faced issues with timely reading of the PPD plant upon intake to the site. The most recent contractual audit showed that 62% of the offenders admitted to HRYCI had their PDD read occur within 72 hours of the initial PPD plant (*Table 3*). Out of the 3 offenders who had positive PPD reactions, none of them had the chest x-ray and provider follow up visit within 2 weeks per DOC policy.

JTVCC:

The addition of a new ICN (since March 2009) was shown to be an asset to JTVCC during the most recent round of contractual audits. Offenders at JTVCC had PPDs read within 72 hours in 83% of the charts reviewed (*Table 4*). However, similar to BWCI and HRYCI, follow-up and tracking of offenders with positive PPD reads was an issue. Out of the 3 positive PPD tests, none had the required chest x-ray and 2 week follow visit with the provider noted in the chart, however all charts reviewed found PPDs to have been appropriately placed at intake and read within the required timeframe.

A Local Operating Procedure ("LOP") describes the Facility's infection control program, and is consistent with statewide policy. A licensed health care provider is designated as having public health/infection control duties, and has received appropriate orientation and training. The Facility has a

functional system for reporting diseases and laboratory test results, which are required by State and federal law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, MRSA, etc.). There are exposure control plans in place for airborne and blood borne pathogens that include:

a) Documentation of new hire and annual training regarding exposure control plans
b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials.
c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure

There is a policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination.

There are engineering controls in place. Sharps containers are secure and easily accessible in areas where sharps are used. Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. Specimen containers are used for transport of biological specimens (e.g., blood, urine). Biohazard storage bins are available. Blood and body fluid spills are cleaned appropriately per policy.

There was only partial compliance with work practice protocols related to infection control. Since March 2009, all Manuals are in place. Spill kits and more personal protective equipment are to be ordered. Although not on the audit tool, JTVCC keeps a refrigerator temperature log, but it is not consistently updated. BCHS staff has made the JTVCC IC nurse and DON aware of deficiencies and supplies that needed to be ordered. Improvement in cleanliness and orderliness of the medical area is needed. Some medical areas were out of soap and paper towels on inspection. Not all storage bins had Biohazard labels and spill kits were all expired. The refrigerator in the lab had specimens and Glucola together, and refrigerators are not labeled appropriately. There was a very limited supply of personal protective equipment, although it was in one designated area.

There is no system for tracking the staff PPD and chest x-rays, but there is a system to track the Hepatitis B vaccinations. BCHS employs a nurse for this purpose. BCHS also tracks all influenza inoculations given during influenza season. There was reporting of communicable diseases for the previous quarter, noting any trends present. There were sanitation reports (institutional and infection control) and follow-up action taken was documented.

(18) Clinic Space and Equipment:

DOC has been working with CMS to identify additional space in the Facilities for examination and treatment, medical records and equipment storage, and staff offices. Since January 1, 2009, DOC has spent over $180,000 on improvements, $75,000 of which was to purchase or repair new equipment and other supplies for medical and mental health delivery at all Facilities. An additional $273,325.43 has been encumbered (earmarked on purchase orders). The funds are being used for the mental health/dental building at SCI. There is an additional $1,146,306.52 of unencumbered funds. BCHS will use the majority of the unencumbered funds for the SCI main medical expansion (these funds will be encumbered once a contractor is selected).

BWCI:

BCHS efforts have led to the relocation of administrative space and medication storage at BWCI. The new administrative area and medication dispensary is now located across the hall of the current medical facility. Relocating the administrative area made space available for four additional examination rooms in the medical facility. All appointments are now held in the examination rooms, thus enhancing the privacy of health care services provided at BWCI. The examination rooms are also equipped with new exam tables, desks, computers and uniform examination equipment. The new administrative area now houses all office space for medical management and administrative staff along with the current offender medical records. In addition to the equipment DOC purchased for the new exam space, DOC purchased computers, storage equipment and desks for the administrative area. The administrative area also houses the relocated medication storage and dispensary area, which has been built with all new or relocated equipment and lockable cabinetry. Additional medication dispensary windows were also added to the area, which allows for separation of the different security levels of the BWCI population. Finally, additional office space has been created for the staff psychiatrist at BWCI.

SCI:

At SCI, construction has commenced on the additional mental health and dental exam rooms with expected completion by early August 2009. Further, expansion plans have been approved for the current medical space and the process for bids has begun. Once completed, the expansion will add another 1,400 square feet to the outpatient services area, which will in turn create additional space for inpatient services for offenders.

HRYCI:

At HRYCI, examination rooms were created in all of the housing units on the East Side of the Facility in order to eliminate the sharing of exam space by two providers. The RN now travels directly to the housing units to perform sick call examinations. Exam tables for seven housing units and a portable cart carrying necessary supplies for the sick call RN was purchased. The use of the housing unit exam space also improves patient flow to providers.

JTVCC:

Renovations were completed in the Infirmary area, which added a new examination and office space for the provider and the mental health staff. Further, the DOC relocated the medical and mental health administrative space in the Security Housing Unit ("SHU") to provide staff with additional workspace and closer proximity to the patients. As noted in previous Compliance Reports, Facility management and BCHS will perform a use management analysis of the general population medical clinic to discover whether medical appointments and provider clinics can be expanded to accommodate offender mental health interviews with clinicians. Presently, these encounters often take place in various locations, outside the clinic, throughout the Facility. DOC is working to ensure that mental health interviews take place in a private setting, to the extent permitted by security needs.

Ensuring the privacy of patients under psychiatric observation in the infirmary remains a challenging task. The psychiatrist often meets with patients under psychiatric observation at cell-side or in the hallway in the infirmary. One improvement worthy of noting is that Special Needs Unit ("SNU") inmates are interviewed by the psychiatrist in the medical area in the Medium Housing Unit ("MHU") and not on the SNU tier.

As was discussed in DOC's July 2007 Compliance Report,[8] each Facility implemented an action plan to address cleanliness issues raised in the first Monitoring Team Report. Under that plan, primary responsibility for cleaning floors, walls, and providing any other janitorial services in the medical units now rests with DOC. CMS is responsible for tasks that are inappropriate for inmate workers, as well as for cleaning, de-cluttering and organizing areas that are primarily under CMS control. For example, CMS is responsible for sharps and hazardous waste disposal, and for maintaining medication preparation surfaces and medication carts. Each Facility continues to monitor medical unit cleanliness under the action plan; DOC and CMS jointly perform environmental inspections on a monthly basis to ensure that the medical units are conforming to NCCHC standards for cleanliness.

[8] *See* Delaware Department of Correction Compliance Report, at 7 and Appendix 4, *available at:* http://doc.delaware.gov/Compliance%20Report.pdf.

ACCESS TO CARE

(19) Access to Medical and Mental Health Services:

Currently, offenders who want to obtain health or mental health care services fill out and submit a sick call form. This is a form used for all medical, mental health and dental requests. Inmates submit the forms into a secure repository, a process that preserves the confidentiality of inmate health information. Nursing staff is required to collect sick call requests on a daily basis and distribute the requests to the appropriate medical unit providers. CMS personnel responsible for collecting sick call forms are required to fill out a "pick up" sheet documenting that the daily collection is made. DOC performs randomly scheduled reviews of the pickup logs, which allows BCHS to monitor compliance with this policy. Additionally, enhancements to DACS now allow BCHS to monitor compliance with sick call policies as part of its quality assurance process. For example, nurse sick call reports are printed from DACS and used in DOC-CMS contractual quarterly audits. Compliance with daily collection requirements, adherence to sick call protocols, and the provision of face-to-face evaluations and follow-up care are some of the issues being monitored during these quarterly audits. A staffing analysis will be conducted by DOC to determine whether Facility RN staffing should be supplemented in order to assure that registered nurses perform all sick call visits.

BWCI:

During the most recent round of contractual audits at BWCI, it was noted that 89% of the sick call slips submitted were triaged by medical staff within 24 hours of receipt with also 89% of the offenders being seen by nursing staff within 72 hours of filing the request (*Table 9*). In the majority of cases, nurses addressed all issues presented by the patient at sick call. If a provider referral resulted out of the nursing visit, the patient's sick call concerns were addressed in 88% of charts reviewed and 43% of the offenders received a visit with the provider within 5 business days of the referral. When prescribed medication as a result of the provider encounter, 86% of the offenders received the medications within 48 hours of the visit.

Symptom-based Sick Call & MAR Assessment Criterion Audit Tool	**DOC Assessment of BWCI**
D1. Sick slips are paper triaged within 24 hours.	89%
D2. Non-emergent requests for sick call are seen in a face-to-face encounter within 72 hours.	89%
D3. Nurse addressed all of the problems presented by the patient at the sick call encounter.	89%
D4. If patient is referred to practitioner from nurse sick call, visit occurred within 5 business days.	43%
D5. Practitioner addressed problem presented by the patient at the encounter.	88%
D6. Patient received formulary medication(s) within 48 hours of provider order, or per provider's order.	86%
D7. Medication orders on MAR reflect dose, route, frequency, start date and nurse's signature.	80%
D8. No lapse in medication reorder.	100%
TOTAL SCORE SPECIALTY/CHRONIC CARE (D)	**83%**

Table 9

Improvement is necessary. Three charts reviewed were of particular concern. One chart had an incorrect entry in DACS and the patient did not get medication renewal appropriately. The second concerned a patient with complaints of vaginal discharge who was seen by a nurse in the appropriate timeframe but not seen by a mid-level provider for treatment until 6 days later. The third chart also indicated a possible sexually transmitted disease. The patient was evaluated by a nurse and referred to a mid-level provider but was not seen until 72 hours later (48 hours late).

SCI:

Of the charts reviewed for symptom based sick call request, 92% of the sick call slips were triaged within 24 hours of the request being picked up by the medical staff (*Table 10*). In addition, 71% of those sick call requests had a face-to-face encounter with a nurse within 72 hours of filing their sick call request. In the event that the offender needed to then be referred to a provider, he was generally seen within 5 business days of the referral. However, if medication was prescribed by the provider as a result of the sick call visit, the offender received the medication within a 48-hour time frame for 38% of the charts that were reviewed.

Symptom-based Sick Call & MAR Assessment Criterion Audit Tool	**DOC Assessment of SCI**
D1. Sick slips are paper triaged within 24 hours.	92%
D2. Non-emergent requests for sick call are seen in a face-to-face encounter within 72 hours.	71%
D3. Nurse addressed all of the problems presented by the patient at the sick call encounter.	87%
D4. If patient is referred to practitioner from nurse sick call, visit occurred within 5 business days.	80%
D5. Practitioner addressed problem presented by the patient at the encounter.	100%
D6. Patient received formulary medication(s) within 48 hours of provider order, or per provider's order.	38%
D7. Medication orders on MAR reflect dose, route, frequency, start date and nurse's signature.	12%
D8. No lapse in medication reorder.	95%
TOTAL SCORE SPECIALTY/CHRONIC CARE (D)	**72%**

Table 10

HRYCI:

Offenders submitting sick call requests had their slips triaged within 24 hours of medical staff receipt for 83% of the charts reviewed (*Table 11*). 44% of the charts, however, indicated that the offender received a face-to-face encounter with nursing staff within 72 hours of the request for sick call services. If referred to the provider for follow up care, 43% of those offenders would be seen by the provider within 5 business days with prescribed medication being distributed to 83% of the offenders within 48 hours of their provider visit.

Symptom-based Sick Call & MAR Assessment Criterion Audit Tool	**DOC Assessment of HRYCI**
D1. Sick slips are paper triaged within 24 hours.	83%
D2. Non-emergent requests for sick call are seen in a face-to-face encounter within 72 hours.	44%
D3. Nurse addressed all of the problems presented by the patient at the sick call encounter.	70%
D4. If patient is referred to practitioner from nurse sick call, visit occurred within 5 business days.	43%
D5. Practitioner addressed problem presented by the patient at the encounter.	100%
D6. Patient received formulary medication(s) within 48 hours of provider order, or per provider's order.	83%
D7. Medication orders on MAR reflect dose, route, frequency, start date and nurse's signature.	20%
D8. No lapse in medication reorder.	100%
TOTAL SCORE SPECIALTY/CHRONIC CARE (D)	**68%**

Table 11

JTVCC:

Problems with timeliness of the sick call process continue at JTVCC. During the most recent round of contractual audits, 17% of sick call slips were triaged within 24 hours of being picked up by the medical staff (*Table 12*). 14% of those offenders received a face-to-face encounter with a nursing staff member within 72 hours of the request being filed. For those offenders who required a provider referral for their sick call issue, 31% were seen by the provider within 5 business days of the referral with 36% receiving their prescribed medications within 48 hours of the provider encounter.

Symptom-based Sick Call & MAR Assessment Criterion Audit Tool	**DOC Assessment of JTVCC**
D1. Sick slips are paper triaged within 24 hours.	17%
D2. Non-emergent requests for sick call are seen in a face-to-face encounter within 72 hours.	14%
D3. Nurse addressed all of the problems presented by the patient at the sick call encounter.	85%
D4. If patient is referred to practitioner from nurse sick call, visit occurred within 5 business days.	31%
D5. Practitioner addressed problem presented by the patient at the encounter.	67%
D6. Patient received formulary medication(s) within 48 hours of provider order, or per provider's order.	36%
D7. Medication orders on MAR reflect dose, route, frequency, start date and nurse's signature.	12%
D8. No lapse in medication reorder.	100%
TOTAL SCORE SPECIALTY/CHRONIC CARE (D)	**45%**

Table 12

37 additional charts were reviewed for this specific aspect of the MOA-style audit. The nurse performed same-day triage of the Health Services Request Form and documented an appropriate disposition in 5% of records. The nurse saw an inmate with urgent complaints on the same day, with routine complaints the following business day in 5% of records reviewed. The nursing subjective history was appropriate to the patient's complaint and included a description of onset of symptoms in 28% of records reviewed. The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.) in 24% of the sample. The nursing diagnosis/assessment was appropriate based on the clinical findings in 36% of the sample. The plan of care and nursing

intervention were consistent with case history, physical findings, and the applicable nursing protocol in 36% of the sample. The nurse referred the patient to a clinician in accordance with the criteria for referral found in the nursing protocol, or accepted in accordance with good clinical judgment, in 38% of the sample. The nurse legibly dated, timed, and signed the form in 14% of the sample. The referral visit to the clinician took place according to protocol: stat-immediate, urgent-same day, routine-within 5 business days, in 22% of the sample.

In order to evaluate access to mental health care and sick call procedure, additional sick call requests were reviewed. 85% of sick call requests were screened within 24 hours and 38% of screened patients were seen within the following 72 hours.

In 95% of the sample, the clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems. In 90% of the sample, the nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated). In 95% of the sample, the clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data. In 90% of the sample, the clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings. In 95% of the sample, the clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up. In 84% of the sample, the clinician documented appropriate patient education related to the diagnosis and treatment plan. In 95% of the sample, all aspects of the treatment plan occurred as ordered within a clinically appropriate time.

(20) Isolation Rounds:

CMS reports that it currently follows NCCHC standards regarding medical care for segregated offenders. A patient roster is printed from DACS and reviewed at the time the rounds are conducted to ensure all patients are seen in accordance with DOC policy and NCCHC standards. Additional documentation of rounds made on mental health patients is maintained in the inmate medical record. Segregation logs are maintained at the Facility in a central location and copies are sent to the CMS Regional Mental Health Director on a monthly basis for review. In the event an inmate is referred for follow-up medical or mental health treatment, this information is documented in the inmate's medical record. Further, DOC policy requires that sick call rounds be conducted on a daily basis by nursing staff.

BWCI:

From the records reviewed it was unclear whether isolation rounds were occurring consistently. Training in this area will be targeted in the next quarter to assure that these are conducted per policy.

SCI:

A review of mental health segregation rounds showed that in the charts reviewed, rounds were conducted and documented three times a week for all reviewed offenders. None of the records reviewed indicated that the offender's placement in segregation was based on the offender decompensating or a lack of receiving proper mental health treatment.

HRYCI:

At last audit, there was one clinician conducting segregation rounds at HRYCI and performance was good.

JTVCC:

The mental health inmates who are housed in segregation are being seen 3 times a week. Documenting clinician contact with the inmate in DACS and consequently filing it remains problematic. Currently, it is not possible to print segregation rounds notes out of DACS for an individual inmate.

(21) Grievances:

Pursuant to DOC policy, the time transpiring between the date of an initial medical grievance and the final appeal response is not to exceed 180 days.

Due to the large volume of medical grievances from JTVCC, the CMS Regional Ombudsman continues to devote a majority of her time investigating and resolving the outstanding medical grievances at this Facility. DOC and CMS continue to work collaboratively on reducing both the number of outstanding grievances and the time required for resolving grievances. Under the DOC – CMS contract, the proper and timely resolution of medical grievances is the responsibility of CMS and requires the participation of CMS staff. Nevertheless, DOC has also provided additional staffing to facilitate and expedite the process of resolving grievances at all Facilities. Unresolved grievances reports are produced in DACS to track outstanding grievances by the BCHS and Facility medical management.

Previously, all medical and mental health grievances were filed in DACS under a generic "Health Issues" category. In order to track trends and issues with grievances, three separate categories were created to differentiate between mental health, dental and medical grievances. After the initial investigation is

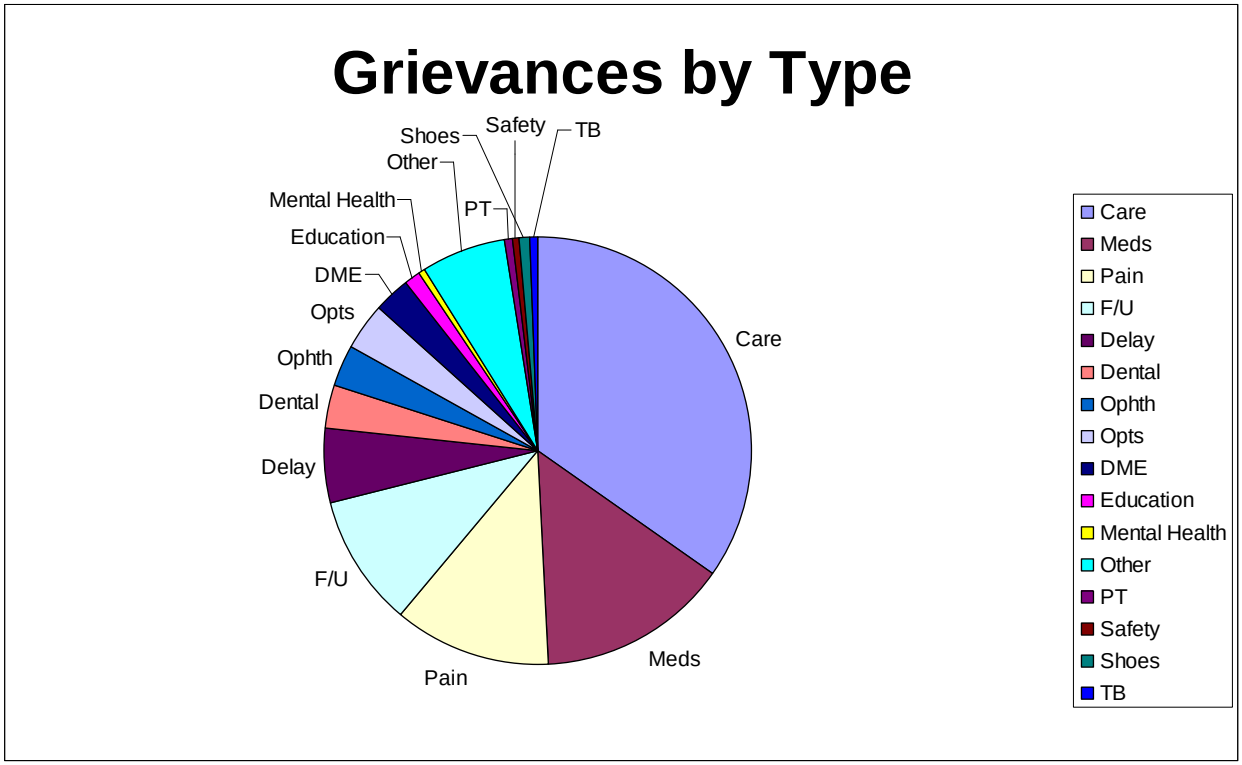
completed on the medical grievance, a hearing before the Medical Grievance Committee ("MGC") can be requested if the inmate is not satisfied with the initial response to the grievance.

To protect the confidentiality of an inmate's information, three members of the medical vendor staff or BCHS staff conduct MGC hearings. DOC grievance officers are also present to record the hearing information in DACS along with any other DOC staff as security needs dictate. These are in-person hearings where the inmate has the opportunity to discuss the medical grievance. After listening to inmate testimony and reviewing the inmate's medical file, the MGC decides whether to uphold or deny the inmate's grievance. The DOC has also developed an MGC log, which is used to track follow-up on MGC decisions. The log contains information regarding cases heard by the MGC, the date of the hearing, and whether decisions were upheld and require follow-up (*e.g.*, a physician visit). Further, if an inmate's grievance was denied by the MGC, the HSA and site Medical Director review the inmate's grievance with the inmate and explain the reason for the denial. Upon the completion of a MGC hearing, the site HSA is responsible for compiling data for the MGC log and producing its contents to the BCHS within two business days. During the subsequent month's Facility MAC meeting, the HSA is required to provide updates on the grievances in the MGC log with the date that resolution occurred. This ensures that grievance outcomes promised to the inmate at the time of the MGC hearing are appropriately tracked and that the Facility HSA addresses systemic issues.

There are no outstanding level III grievances at any Facility in the State at the time of this report.

In addition to formal grievances, BCHS continues to track, monitor and resolve medical complaints ("informal grievances") received from multiple sources (including offenders, families of offenders, attorneys, the Judiciary, the Legislature, the Governor's Office, the Commissioner's Office, the Attorney General's Office, the American Civil Liberties Union and other private organizations, DHSS, the Public Defender's Office and other State agencies, DOJ, DOC's legal counsel, and the general public). A report on BCHS's analysis and resolution of these complaints is expected in August 2009.

BCHS tracks, monitors, reports upon and resolves hundreds of grievances (formal and informal) each quarter. The number of informal grievances (medical complaints from all sources) far outweighs the number of grievances BCHS receives via the formal system. The graph below shows the breakdown, by type, of all grievances (formal and informal) received over the past two months. Concerns about quality of care are the most prevalent type of grievance (formal or informal) that BCHS receives; BCHS investigates all of these to conclusion (i.e., resolution of the medical issue).



Graph 3: In the past quarter, BCHS has investigated over 200 concerns from State agencies, private sources, and the public. By far, the volume of these "informal" grievances (i.e., medical concerns brought to the attention of BCHS outside of the formal grievance process) far outweighs the volume of formal grievances received (approximately 80% "informal" and 20% formal). Among all grievances received, formal or "informal", quality of care was the most frequently cited issue, followed by continuity of medication concerns.

CHRONIC DISEASE CARE

(22) Chronic Disease Management:

The BCHS Medical Director is working with the CMS Regional Medical Director, the CMS Infectious Disease Consultant, and the Site Medical Directors to develop an improved statewide Infectious Disease protocol.

If an inmate presents with chronic care needs at intake or sick call, DOC policy requires the nurse to complete a chronic care referral form to initiate a clinical evaluation. At the conclusion of the clinical evaluation, the clinician is required to document a treatment plan. The treatment plan should include diagnostic and therapeutic interventions, along with patient education for each chronic illness. The clinician determines the frequency of chronic care appointments, based on the degree of disease control being achieved and maintained.

The provider is expected to order medications and laboratory tests as needed, and to time those orders so that medications do not run out before the next visit and so that laboratory test results are available at the time of the next appointment. CMS is required to follow NCCHC standards for chronic disease care and treatment, and these standards are outlined in the CMS Chronic Care Guidelines handbook. Further, the DACS scheduling function for chronic care appointments automatically schedules the next inmate visit within the time frame indicated by the provider. Continual monitoring using DACS reports, the Audit Tool and the site quality assurance process ensure compliance with chronic care policies and standards.

BWCI:

Chart review indicated that the majority of offenders were enrolled in the appropriate chronic care clinic with problem lists updated appropriately. 65% were seen in a timely manner between appointments and 75% of the charts contained the appropriate documentation including education and follow up. Consults from chronic care clinic were followed up on in 92% of charts reviewed. Labs were ordered from chronic care visit, followed up on, and reported to the patient in 40% of charts reviewed. In general, ID consults were not ordered on Hep C patients unless they were symptomatic or had elevated liver enzymes ("LFTs"); there is no consistent policy on when to draw Hep C viral load, though Hep C viral load is drawn at BWCI a greater percentage of the time with Hep C patients than at any other site in the State. A consequence of this appears to be that more Hep C patients are being documented as having cleared the virus (when Hep C viral load is "undetectable") at BWCI than at other sites in the State. The current policy is to check this once and then to follow LFTs for a period thereafter as a follow-up.

In two of the cases reviewed, an ID consult was ordered but the patient had not yet been seen. In two other cases, patients had elevated liver enzymes but had not been seen by the ID consultant. In one case, there were no recent Hep C labs available for review, and no ID consult. All but one chart had up to date chronic care visits – the one that was not up to date had the most recent chronic care clinic visit on 8/27/08; the patient appeared to have left institute and been readmitted on 5/22/09- no chronic care visit had occurred since then. Two patients reviewed did not have an up to date HIV viral load on file, and two other patients had low CD4 counts but no ID consult. The BCHS Medical Director reported these findings to the Site Medical Director to ensure the patients received appropriate care and follow-up.

The management of hypertension ("HTN") at BWCI is improving, but further improvement is necessary. In one chart, HTN was reported at intake screening but was not addressed at the subsequent chronic care visit. BCHS investigation showed the patient's blood pressure to be within normal limits. In another chart, while the patient's HTN was well managed medically, the progress note of 5/9/09 was poor. One chart showed a patient seen for elevated blood pressure on 5/13/09; the patient was seen by a Provider on 5/21/09. While medications were appropriately increased, the patient was not brought back to clinic to reassess the effectiveness of this change. The patient's most recent chronic care visit was on 3/18/09.

One chart review showed angioedema secondary to Lisinopril (i.e., an adverse effect of this blood pressure medication). The patient demonstrated edema on 5/30/09. On 6/14/09, the patient's blood pressure continued to be elevated. Blood pressure was checked at 3 weeks and 12 weeks and the patient is being reassessed at chronic care clinic to actively manage blood pressure at three-week intervals. Two charts were particularly deficient in terms of documentation. In one chart, progress notes documenting HTN management were missing, and no history and physical could be found. In another, there were no progress notes related to HTN except that associated with the initial history and physical.

Diabetes management at BWCI was better than HTN management but is still in need of improvement. In one chart, history of diabetes was noted on intake but there was no further documentation of diabetes management. In another chart, the Provider appropriately called for medication orders; orders were not received until the following day for the patient to use the medications she had with her at intake. In another chart, a patient's blood sugar was elevated (BS=239) on admission. Since intake, the patient's blood sugar has been in poor control (ranging from 37-190). The patient was recently re-evaluated by the Provider on 6/9/09; insulin orders were changed resulting in better control.

SCI:

Audits conducted at SCI revealed that 78% of the offenders are being seen in the appropriate time frame between their appointments. Further, 98% of the offenders were enrolled in the appropriate chronic care clinic and 84% of the charts contained the current problem lists. However, the documentation appeared to be problematic with 48% of the charts containing proper chronic care notes.

HRYCI:

The most recent audits indicated that chronic care clinics at HRYCI continued to be problematic. Of the charts reviewed, 52% were seen timely between their appointments with 74% of the charts containing the proper documentation for the offender's visit. Most offenders were enrolled in the appropriate chronic care clinic with 82% of the charts indicating the problem list was current.

JTVCC:

An audit of chronic care charts at JTVCC indicated that 92% of the offenders were being seen timely between their appointments. 72% of those offenders had proper documentation relating to the chronic disease noted in the chart. All charts reviewed had the offender enrolled in the appropriate chronic care clinic with 94% of the charts containing up to date problem lists.

The quality of chronic care at JTVCC is mixed with differences being primarily provider-driven. Systems deficiencies deepen provider-driven issues leading to inconsistency of care for offenders with chronic disease.

There are two areas of immediate concern:

- First, there is a breakdown in the process for collection, reporting to physician and follow-up/management of laboratory results. This is partly explained by the absence of a regular phlebotomist for an extended period (a new phlebotomist has recently been hired to correct this), however, the process itself is flawed and BCHS is investigating to determine how the system can be repaired to improve lab results management.
- Second, there have been issues with replacing providers who take sick leave, which requires re-scheduling patients and results in backlogs. BCHS is working to develop a process by which locum tenens providers are called in to temporarily replace providers who must be absent from the Facility.

BCHS has addressed these concerns with CMS and action is being taken to assure care is consistently high quality.

(23) Immunizations:

As of December 22, 2008, 36 juveniles were housed at HRYCI. Upon intake, the Infection Control Coordinator reviews the juvenile's immunization history. CMS continues to work collaboratively with DOC, the Delaware Department of Services for Children, Youth and Their Families and the DPH Immunization Program to obtain the records, if available, of all juveniles housed in DOC facilities. One tool being used by the DOC and CMS to assist in this process is the State's immunization records online data bank (known as "VACAttack"), which allows the Infection Control Nurse access to the State's data regarding all immunizations that were administered in Delaware. Once juvenile immunization information has been obtained, the DOC ensures that CMS updates the juvenile's immunizations as needed, in accordance with nationally recognized guidelines and Delaware school admission requirements.

In addition, DOC has obtained hepatitis A and B vaccinations for 1520 offenders and about 200 DOC security staff. DOC is working collaboratively with CMS to identify offenders who are candidates for the hepatitis immunizations because of chronic conditions or other risk factors. All immunization information is maintained in the inmate's unified medical record. Influenza vaccinations were also made available to offenders at all DOC Facilities and to DOC staff.

In general, the immunization form at all sites tends to be used primarily to screen for PPD- there was limited information on past immunization to allow clinicians to make decisions about boosters; immunizations were not documented as up to date for patients with immune suppression or respiratory diseases (e.g. influenza and pneumovax). BCHS is working with CMS Records Supervisor to document a patient's full immunization record to ensure immunizations are up to date.

MEDICATION

(24) Medication Administration and (25) Continuity of Medication:

Nurses are required to provide medications at times reflected on the Medication Administration Records ("MAR"), in accordance with medication orders. Normally, first medication passes are done during the morning hours, with a second and third medication pass occurring during the afternoon and evening hours, respectively. Additional passes include lunchtime blood glucose checks and insulin injections as

indicated. CMS and DOC continue to work collaboratively to ensure that medication passes are performed within the appropriate time frame. At JTVCC, nursing schedules were re-adjusted, offender meals times were changed and staffing was enhanced to ensure that offenders received their medications in a timely manner.

At all sites, at the end of a shift, the medication administration nurse reviews the Medication Administration Records to identify patients who missed or declined medications, and is required to follow up appropriately. If a patient is non-compliant for three consecutive doses of medication, the patient is scheduled to meet with a Provider to discuss the noncompliance and its possible ramifications for the inmate's medical treatment. Pursuant to DOC policy, the site DON consistently monitors medication administration, with ongoing medication administration education provided to staff responsible for distributing medication to offenders. Additional in-service training has been provided to the nursing staff regarding proper MAR documentation and narcotics accountability. Further monitoring of this policy is conducted through quarterly DOC-CMS contractual audits and the Facility's quality assurance process to ensure that new medication orders are implemented and delivered in a timely manner. This process is also used to monitor ongoing compliance with the medication ordered by a Provider, the appropriate maintenance of MARs, and medication continuity.

BWCI:

Review of offender charts requiring psychotropic medications be verified and ordered within twenty-four hours of their arrival to BWCI, indicated that 83% of those offenders received their medications within the required time frame (*Table 13*). The majority of charts reviewed for timely medication reorders indicated that medications were reordered and provided to the offender in a timely manner. One chart reviewed showed a medication order that was 10 days late; the patient had to put in a sick call slip to receive the appropriate medication.

SCI:

During the most recent contractual audit, a review of offender charts requiring psychotropic medications be verified and ordered within twenty-four hours of their arrival to SCI indicated that 67% of those offenders received their medications within the required time frame (*Table 14*). 95% of the charts reviewed for timely medication reorders indicated that the medications were reordered and provided to the offender timely.

HRYCI:

In the sample of charts of mental health patients who received orders for psychotropic medications at HRYCI, 38% of patients received the prescribed psychotropic medications in a timely manner (*Table 15*).

JTVCC:

In the sample of charts of mental health patients who received orders for psychotropic medications, 87% patients received the prescribed psychotropic medications in a timely manner (*Table 16*). 20% of the charts reviewed, however, did not include June 2009 MARs.

(26) Medication Management:

DOC policy requires medication storage rooms to be locked at all times, and inspections by DOC compliance personnel confirm adherence to this policy. Keys to medication rooms are kept with a member of the nursing staff and used to enter and exit the dispensary. CMS currently has two different policies governing medication disposal. For narcotics and other controlled substances, a log is maintained at each Facility documenting the receipt, administration, and disposal of the medication. All other medications that are discontinued (because an inmate has been released or for medical reasons) are returned to the vendor pharmacy by CMS. In addition, CMS had Clinical Programs personnel from their corporate site visit each Facility and provide assistance in reorganization of the medication storage rooms. Medication storage is being reviewed to ensure par levels of medications are maintained and whether stock medication is appropriate.

BWCI:

80% of the charts reviewed showed medication orders on MAR reflected dose, route, frequency, start date, and nurse's signature. One expired medication (albuterol) was discovered and reported to staff to return to the pharmacy contractor. One patient's medication (brought by the patient herself on incarceration) needed to be inventoried. This was of particular concern as one of the medications un-inventoried was lithium (potentially nephrotoxic). One nurse had not signed any of the MARs. BCHS informed the Director of Nurses, and corrective action was taken.

The narcotics count was accurate but nurses can improve management by spot-checking and ensuring signatures. A potential problem with methadone was investigated by management at the Facility, BCHS staff and State Police. All staff that may have had access to the narcotics cabinet or room were drug tested and the issue was resolved. None of the tests was positive. It was determined that a potential problem with sealing the caps on the methadone bottles may have caused the potential problem. The facility preparing the methadone for distribution to offenders was notified along with the site management

and staff.

JTVCC:

In 95% of charts in the sample, the medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills). In 80% of the cases, the clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used). In 50% of charts reviewed, the clinician documented an appropriate clinical note that corresponds with the initial medication order. In 30% of charts reviewed, the nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour). In 85% of cases, the nurse or pharmacy accurately transcribed the physician order onto the MAR. In 80% of cases, the MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered. In 65% of cases, there is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the patient. In 0% of cases, for inmates who missed medications on 3 separate days (or >50% of medications in a week's period of time), the record shows that the nurse notified the clinician who saw the patient to assess the reasons for missing the medication and took appropriate action. In 30% of cases of discontinued medications, the nurse discontinued medications according to policy. 0.5% of MARs reviewed were neat and legible, and contained legible initials, signatures, and credentials of nursing staff who have administered medications to patients.

In one chart, a three-day gap was noted from when the medication was ordered and when the medication began to be administered. In one chart, the documentation of Atenolol dosage was so problematic that it appeared the patient had been changed from 25 to 100 mg without a corresponding order. Upon investigation, it appears the patient received 25mg Atenolol doses in May, June and July. The MAR documentation was not clarified to unambiguously reflect the patient's medication dosage until July.

In another chart, new orders were written on 6/24/09, but not noted until 6/26/09. The order date was not changed on the MAR; only the stop date was changed. In one housing unit, only one nurse's signature was consistently recorded on the back of the MARs.

EMERGENCY CARE

(27) Access to Emergency Care:

Offenders who require acute emergency care are transported from a Facility to an offsite health care Provider for emergency evaluation and treatment as necessary. Since January 2008, over 300 offenders have received more than 1331 days of offsite acute emergency care. The Regional Medical Director reviews each emergency care case to ensure that staff took appropriate measures before the emergency occurred, and to identify alternatives that might have averted the emergency and the need for acute care.

(28) First Responder Assistance:

Currently, all DOC correctional employees attend a nine-week course, "Correctional Employee Initial Training," which is provided by DOC, before commencing employment at a DOC Facility. During this training, all security staff receives seven hours of CPR training and an additional seven hours of First Aid training. First Aid training includes the use of an emergency cut-down tool. This class also includes training on Automatic Emergency Defibrillator machines. All security staff receives another seven hours of training on "Special Medical Topics." This class provides training on such issues as contagious disease and blood borne pathogens. CMS medical professionals teach all three classes.

In addition to the initial orientation training, security staff receives yearly refresher training on CPR, First Aid, and use of Automatic Emergency Defibrillator machines. Refresher training for "Special Medical Topics" is provided every three years. All security staff employees are issued equipment to be used during first line emergency response (CPR masks, latex gloves and a glove pouch) as part of their uniforms. Additionally, emergency cut-down tools have been distributed at all DOC facilities and are readily accessible to staff. Logs of employee training attendance are maintained by the DOC Employee Development Center located at the DOC Central Administration Building and are available for inspection by the Monitoring Team.

BWCI:

First responder equipment is available in offender areas. Use of equipment is part of the ongoing training by the Educational Development Center. No situations (where a first responder was needed and equipment was unavailable) have occurred since the last MOA audit.

JTVCC:

First responder equipment is available in offender areas. Use of equipment is part of the ongoing training by the Educational Development Center. No situations (where a first responder was needed and equipment was unavailable) have occurred since the last MOA audit.

MENTAL HEALTH CARE

Data for multiple, integrated aspects of Mental Health services are captured in form C. As such, the data for all Facilities are grouped together at the beginning of the section, rather than broken out by MOA paragraph.

Mental Health Services Assessment Criterion Audit Tool	DOC Assessment of BWCI
C1. Inmates with non-emergent positive screening for MH problems are seen by qualified MH professionals within 72 hours.	100%
C2. Mental Health Screening is completed by qualified health professional within 24 hours of intake.	100%
C3. Patients on verified psychotropic medications will have medication(s) ordered within 24 hours of intake.	83%
C4. Inmates on suicide observation are seen daily for assessment by a qualified MH professional.	90%
C5. Inmates released from suicide watch are seen by MH professional within 24 hours after release.	90%
C6. Laboratory testing for patients on psychotropic medications has been completed.	100%
TOTAL SCORE INTAKE (C)	**94%**

Table 13

Mental Health Services Assessment Criterion Audit Tool	DOC Assessment of SCI
C1. Inmates with non-emergent positive screening for MH problems are seen by qualified MH professionals within 72 hours.	95%
C2. Mental Health Screening is completed by qualified health professional within 24 hours of intake.	95%
C3. Patients on verified psychotropic medications will have medication(s) ordered within 24 hours of intake.	67%
C4. Inmates on suicide observation are seen daily for assessment by a qualified MH professional.	100%
C5. Inmates released from suicide watch are seen by MH professional within 24 hours after release.	100%
C6. Laboratory testing for patients on psychotropic medications has been completed.	85%
TOTAL SCORE INTAKE (C)	**90%**

Table 14

Mental Health Services Assessment Criterion Audit Tool	DOC Assessment of HRYCI
C1. Inmates with non-emergent positive screening for MH problems are seen by qualified MH professionals within 72 hours.	95%
C2. Mental Health Screening is completed by qualified health professional within 24 hours of intake.	95%
C3. Patients on verified psychotropic medications will have medication(s) ordered within 24 hours of intake.	38%
C4. Inmates on suicide observation are seen daily for assessment by a qualified MH professional.	100%
C5. Inmates released from suicide watch are seen by MH professional within 24 hours after release.	40%
C6. Laboratory testing for patients on psychotropic medications has been completed.	36%
TOTAL SCORE INTAKE (C)	**67%**

Table 15

Mental Health Services Assessment Criterion Audit Tool	DOC Assessment of JTVCC
C1. Inmates with non-emergent positive screening for MH problems are seen by qualified MH professionals within 72 hours.	95%
C2. Mental Health Screening is completed by qualified health professional within 24 hours of intake.	100%
C3. Patients on verified psychotropic medications will have medication(s) ordered within 24 hours of intake.	88%
C4. Inmates on suicide observation are seen daily for assessment by a qualified MH professional.	100%
C5. Inmates released from suicide watch are seen by MH professional within 24 hours after release.	100%
C6. Laboratory testing for patients on psychotropic medications has been completed.	83%
TOTAL SCORE INTAKE (C)	**94%**

Table 16

(29) Treatment:

Mental Health Services are available to all offenders at each Facility; qualified mental health professionals provide these services.

BWCI:

Treatment plans were reviewed in April and again in June. The review in April revealed several positive developments, but the follow-up review indicated that the progress was not sustained in all areas. Staffing has remained consistent so the reason for this could not immediately be determined.

In April, 80% of all the records reviewed had up-to-date, properly completed treatment plans. In June, timeliness of reviews remained consistent; however, the plans were often incomplete.

In April, 75% of the treatment plans reviewed were problem-oriented and patient-specific. Information in

the plans appeared to reflect the psychiatrist and mental health clinician notes. In June, 10% of plans reviewed were problem-oriented and patient-specific. 90% of plans had only one problem listed and 60% merely quoted something the patient said during the encounter that was not relevant to the reason the patient was being treated. Examples include, "I am just having a problem with my STRD" (short term release date) and "taking Paxil for depression." Additionally, the interventions listed in the plans were nearly identical in many of the records reviewed, despite significant differences in the actual clinical presentation of the patients.

In April, 50% of treatment plans reviewed were updated based on progress made toward identified treatment goals. This by far was the weakest area. Although most clinicians included patient- specific goals, adjustments were rare when patients were failing to respond to current treatment. In June, no definite progress in this area could be determined

JTVCC:

As of 7/23/2009, no groups were being conducted on the compound. However, the mental health director reported that the mental health clinicians facilitate an average of three to four groups on the compound. Group will resume in August 2009. Groups cover topics such as grief, forgiveness, depression, and substance abuse. In addition to two weekly community meetings, four weekly groups are conducted in the Special Needs Unit ("SNU") by mental health clinicians. Also, there is a daily group in the SNU, facilitated by the activity aid. According to the mental health director, the psychiatric nurse conducts four weekly groups covering subjects, such as substance abuse, psychotropic medications, and depression. Currently, most of the SNU groups are conducted in the classroom in the Medium Housing Unit ("MHU"). Coordinating the use of the classroom for the SNU groups with other parties remains a challenging task. Community meetings are conducted in the common area on the SNU tier. The T1 building on the compound has been designated as a housing unit for inmates with mental illnesses, who pose minimal risk to the safety of themselves or others. The SNU currently has approximately 40 patients, with a maximum capacity of 50 patients. The T1 housing unit has approximately 35 patients with a maximum capacity of 50 patients.

Ten SNU patients were interviewed to assess their satisfaction with housing and treatment aspects. All ten patients expressed satisfaction with access to mental health care. Not all of them, however, were satisfied with the limited recreational time available. SNU residents receive 2 hours of recreational time a day during weekdays. One SNU patient reported that SNU residents have far less recreational time than inmates on the compound. He further stated that SNU residents are being punished because they are mentally ill.

In order to assess mental health treatment, approximately 20 additional charts were reviewed. In general, inmates were seen for their routine mental health and psychiatric visits. 85% of charts reviewed included the required monthly visits for 2009. In one case, however, the inmate was not seen in 4 out of the 7 months since the beginning of 2009. In another case, the chart was missing 2 monthly routine visits.

Concerning psychiatric visits, 90% of charts reviewed included the required psychiatric visits. In some cases, inmates were seen sooner than the 90 days required between psychiatric visits.

(30) Psychiatrist Staffing:

CMS reports on its July 2009 recruitment report that all Psychiatry positions are filled.

When an inmate receives care from a psychiatrist, a mental health clinician is present during the visit to take notes and document modifications to the treatment plan as needed. The psychiatrist oversees Mental Health Treatment team meetings, which are conducted between the psychiatrist, clinician, and inmate.

BWCI:

CMS reports on its July 2009 recruitment report that all Psychiatry positions are filled. A psychiatrist is currently scheduled on site approximately 20 hours per week and is provided Mondays, Wednesdays and Thursdays. The psychiatrist does not regularly participate in weekly staff meetings, but BWCI staff report speaking with him about clinical issues on an informal basis. The BCHS Mental Health Administrator has been charged to work with the CMS Regional Psychiatrist and Mental Health Director to ensure that the psychiatrist at BWCI participates formally on a routine basis with site mental health staff.

SCI:

SCI is currently staffed with one psychiatrist who oversees all of the mental health services for the site. He participates in the weekly staff meetings, which is reported in the Director's log book. Staff indicates that the psychiatrist's presence at the meetings has been very beneficial. To expand coverage of psychiatric services, on January 14, 2008, DOC launched a tele-psychiatry program. This program allows the psychiatrist located in the Northern region of Delaware to provide services to offenders at SCI through a video-conferencing system. CMS reports that about 8 hours a week of services through tele-psychiatry are provided to offenders at SCI. With the recent addition of on-site psychiatry hours at SCI, the need for tele-psychiatry will decline. BCHS will conduct a staffing analysis at all Facilities to ensure the hours of psychiatrist care are appropriate.

HRYCI:

Per the July HRYCI staffing report, there is a staff psychiatrist at HRYCI and there are two PRN (as needed) psychiatrists.

JTVCC:

As of 7/23/09, there are 2 psychiatrists working at JTVCC. One of them works approximately 25 hours per week and has been working at JTVCC since 1/3/2006. The other psychiatrist works approximately 38 hours a week and has been employed at JTVCC since 7/19/2008. The two psychiatrists have set schedules and each one of them works the same hours and days every week. The mental health director reported that the psychiatrist, who is currently working at Sussex Correctional Institution, is expected to provide an additional 16 hours of psychiatry time at JTVCC starting July 27th, 2009

According to the mental health director, the full time psychiatrist on the compound regularly participates in weekly staff meetings and offers feedback on individual cases and educates staff on psychotropic medications. The compound psychiatrist participates once a month in the minimum security MDT meeting and offers feedback concerning mentally ill patients.

(31) Administration of Mental Health Medications:

DOC has implemented a set of clinical protocols that set forth laboratory tests required for patients being treated with psychotropic medications. A psychiatric nurse is assigned at JTVCC for the SNU housing units. The nurse monitors psychiatric medications prescribed to offenders in these units to ensure continuity of the medications and evaluate potential side effects. All medication distribution, including psychotropic medication, is documented on the offender's MAR. Additional monitoring of compliance with policies and protocols relating to the administration of mental health medications occurs through quarterly DOC-CMS contractual audits and the Facility's quality assurance process. In particular, these tools are used to ensure that prescribed medications are received in a timely manner. These processes are also used to monitor and improve medication continuity, adherence to daily medication administration schedules, and the maintenance of appropriately documented MARs.

BWCI:

Difficulties with effectively bridging inmate's medications when they arrive at BWCI continue. A review of records for recent intakes, acknowledged by interviews with staff, indicated that inmates often go for a significant period of time before medications are resumed. Further, when the offender then receives the medications they are not the same medications they were stabilized on in the community. In addition, in two records reviewed, the psychiatrist indicated he intended to order a particular medication on his

encounter note, but never actually ordered the medication on a physician's order sheet. Therefore, the inmates never received the medication. A transcription error, not related to medication, was noted in one other record. The audit also revealed that medication consents were often not signed by the psychiatrist. (See also MOA Paragraph 4).

Psychiatric medications were renewed in a timely manner and adjustments were made based on patient report of symptoms. Bridge orders were routinely completed, however in each of the intake records reviewed for inmates who were on non-formulary medications when they arrived, the inmates were placed on a formulary medication after being seen by the psychiatrist. It was unclear if any of these patients had been tried on these formulary medications in the past and failed treatment.

SCI:

The audit conducted at SCI showed that medication renewals were generally timely. However, when new medications were started or changes to current medications were made, the change did not result in the offender being seen earlier than the standard 90 days. The only exception found to the standard 90-day appointment, occurred when the offender was referred by medical staff or reported negative symptoms prior to the 90 days lapsing. In these instances, the offender was seen in a timely manner.

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During both the Mental Health Treatment Administrator's independent audit of charts and the most recent quarterly contractual audit, there appeared to be some difficulties with effectively bridging inmate's medications when they arrive at the Facility. A review of five records for recent intakes, acknowledged by interviews with staff, indicated that inmates often go for a significant period of time before medications are resumed. Further, when the offender receives medications they are not the same ones they were stabilized on in the community.

HRYCI:

There are significant problems with mental health continuity of medication at HRYCI. Audits show a majority of patients get good continuity of medication therapy when admitted or transferred to HRYCI, but there is a significant minority that do not. Some patients came from the psychiatric hospital with current orders that were not bridged on intake.

JTVCC:

In the charts reviewed to evaluate the administration of psychotropic medications, 87% of patients received their medications in a timely manner. Doses, starting dates, and expiration dates were noted on the MARs. Not all the MARs, however, included the prescribing physician's name. The psychiatrists

appeared to be ordering the necessary labs. In some cases, however, the medical staff did not process the lab orders in the required time frame. In one case, lab work was ordered in May 2009 and was not completed as of 7/23/09.

The difficulties with bridging non-formulary medications for new arrivals appeared to have eased since the last monitoring visit. The mental health director and the psychiatrist reported that non-formulary requests are being processed by the chief psychiatrist within 24 hours from the time they are requested. Also, if a non-formulary medication was authorized once, the psychiatrist on site doesn't need to provide a rationale for prescribing it every time he needs to renew it.

BCHS has authorized the CMS Regional Psychiatry Director to conduct a pilot program at HYRCI to stock non-formulary psychiatric medications based on use (rather than stocking based solely on whether a medication is on the formulary). BCHS will analyze any improvements to bridging of psychotropic medications attributable to the pilot program to address bridging concerns at all Facilities.

(32) Mental Illness Training:

During the seven-hour initial training course regarding "Special Medical Topics," DOC staff receives instruction on various issues regarding mental illness. The course is taught by a qualified health professional from CMS. This training teaches DOC staff to make observations based on mental health needs and to request behavioral observation and referral to Mental Health Staff when needed. Refresher training for this topic is provided every three years; with the most recent training occurring in 2008. Further, additional training has been provided for all security staff assigned to the JTVCC SNU, HRYCI transition unit, BWCI Harbour House, segregation units and Infirmary housing areas. Logs of employee training and attendance are maintained by the DOC Employee Development Center, located at the DOC Central Administration Building, and are available for inspection.

BWCI:

All mental health staff and the psychiatrist at BWCI have completed the required suicide prevention training. Training on DOC mental health policies, including mental health involvement in the disciplinary process, was provided to mental health staff since the last monitoring visit.

The health care contractor did not provide specific training to the SNU and infirmary staff at BWCI as they did at the other sites. The BCHS Mental Health Administrator is working with site mental health leadership to assure that training occurs.

JTVCC:

All staff identified in the audit received the required suicide prevention training and refresher.

(33) Mental Health Screening:

As noted in the Screening and Treatment section of this report, a mental health screening is performed on each incoming inmate as part of the initial intake screening. If an inmate answers "yes" to any questions on the mental health portion of the screening, the inmate automatically receives a mental health referral through the DACS system and assessment by a mental health professional within twenty-four hours. Additionally, as is discussed in greater detail below and in ¶ 10, the nurse performing an intake screening has discretion to refer an offender to mental health if the referral is believed to be necessary, even in the absence of positive responses on the mental health portion of the screening.

All inmates in the State are screened for mental health conditions at intake.

(34) Mental Health Assessment and Referral:

Any medical or mental health professional can refer an offender to psychiatry. Additionally, any DOC or vendor staff can ask for a mental health assessment if the situation warrants. When a referral is made, the offender will be seen for a mental health assessment, which is to be completed within five to ten days from the date of the referral. To assure confidentiality, any self-referrals for mental health treatment are made through the sick call procedure. Random audits of sick call pick-up logs and quarterly use of the Audit Tool at all Facilities help ensure adequate response times to sick call requests for mental health issues.

BWCI:

While referrals are generally being seen in a timely manner, documentation of clinical presentation of mental health issues is rarely found. There are concerns regarding the content of the actual responses. Responses are given by checking boxes rather than clinical narrative; this can lead to inappropriate and inaccurate diagnosis and inferior treatment. In one of the intake records reviewed, the referral was dropped and never seen.

JTVCC:

Response time to referrals was slow at JTVCC. The quality of documentation was in need of improvement and did not adequately discuss the patient's mental health picture.

(35) Mental Health Treatment Plans:

Treatment plans are initiated by a mental health professional at the first visit and reviewed at least every three months by the Mental Health Treatment team. Each Facility maintains a Mental Health roster that lists each individual inmate who is receiving mental health services, their diagnosis and current mental health medications. The list also specifies the date of the next treatment plan review scheduled for the inmate to ensure that the reviews are performed in a timely manner. Inmate mental health treatment plans are maintained in the inmate's unified medical record.

BWCI:

Treatment plan progress at BWCI was not sustained in all areas. Timeliness of reviews remained consistent; however, the plans were often incomplete. 10% of plans reviewed were problem-oriented and patient-specific. 90% of plans had only one problem listed and 60% consisted only of patient quotes. Interventions listed in the plans were nearly identical in many of the records reviewed, despite significant differences in the actual clinical presentation of the patients. Half (50%) of treatment plans reviewed were updated based on progress made toward identified treatment goals (see MOA paragraph 29).

SCI:

During the review conducted at SCI, it was discovered that the quality of treatment plans varied by the Mental Health Clinician who was writing the report. While it appeared that some of the recommendations made during recent trainings had been implemented (e.g. making them more problem specific) the actual plans often failed to correspond to the problems. 11% of records reviewed had treatment plans out of date and one record had no treatment plan.

In addition, the review of mental health sick call requests showed that responses to the requests were generally timely. Actual responses, however, did not always address the concerns raised in the sick call request for mental health services. There were appropriate responses in some instances, but in others less so. The variable appeared to be related to the Mental Health Clinician conducting the sick call encounter. One example of an inadequate response was when an offender reported he was extremely anxious and on the edge. The inmate was seen and his increased anxiety was noted, but the plan was to "continue mental health program" and contact mental health as needed. This response appeared to be typical of certain clinicians. The findings of the audit were brought to the attention of the Mental Health Director for review and action.

HRYCI:

The CMS Regional Mental Health Director has instituted a procedure for clinical supervision. Treatment plans appeared more complete but intervention was not always appropriate in that there was little attempt to remedy the identified problem. Progress notes were inadequate in their documentation. Physician visits are better, with patients being seen approximately every 90 days. There were delays with the first visit with the psychiatrist.

JTVCC:

15% of charts did not include treatment plans. An additional 10% of charts did not include current treatment plans. In 53% of up to date treatment plans reviewed, the content of the treatment plans was poor. Treatment goals and intervention strategies were not clearly written and some parts of the treatment plan form were left blank. Furthermore, the problems listed on the treatment plan were not specific. For instance, on one treatment plan the problem was stated as: "Inmate remains medication compliant." On another treatment plan, the clinician defined the problem as: "Calm and stable, no distress."

(36) Crisis Services:

When a crisis situation occurs, the inmate is immediately assessed by a mental health professional. Less severe situations could involve an inmate who requires only short-term monitoring or psychiatric observation. The most extreme cases result in referral and transfer to the Delaware Psychiatric Center ("DPC") or an acute care facility, as clinically indicated. BCHS meets on a monthly basis with DPC staff and DOC security to discuss the movement of DOC inmates to and from DPC, in order to promote continuity of care for the offender. When clinically indicated, an inmate at the Facility who becomes a risk for harm to self or others may require therapeutic restraints or involuntarily medication. A DOC policy regarding use of involuntary medication was submitted to the DOJ and approved. When these measures are not successful in stabilizing the inmate, the inmate is transported to an acute care hospital. DOC policies prohibit the use of administrative/disciplinary isolation in response to psychiatric emergencies.

BWCI:

Two BWCI inmates were admitted to the Delaware Psychiatric Center (DPC) since January 2009. Female bed space continues to be at a premium at DPC (only 6 total beds). Although there are no patients waiting to be transferred at this time, the limited bed space has the potential to cause a backlog and some delays. Steps have been taken to communicate these concerns to the court. During this reporting period, the clinical staff from the forensic unit at DPC met with judges from Superior Court to ask for increased

flexibility in sentencing in an effort to address this concern. BCHS will continue to coordinate with the court.

JTVCC:
Four inmates were transferred from JTVCC to DPC for stabilization and treatment since the beginning of 2009.

(37) Treatment for Seriously Mentally Ill Offenders:
Currently there are various programs for offenders with mental health needs that include screening, assessment, routine mental health counseling (occurring on a monthly basis, at minimum), psychopharmacological intervention with a review by a psychiatrist at least every 90 days, group treatment, SNU housing and psychiatric observation for offenders who are either suicidal or have decompensated to the extent that they cannot be safely managed in their normal housing unit. If an inmate cannot be managed with mental health services provided at the Facility, a referral to Delaware Psychiatric Center is made.

BWCI:
Eight group and two community meeting sessions are being offered to residents of the special needs unit. No other programming is offered, contrary to standard practice. The BCHS Mental Health Administrator will work with Regional Mental Health Director, Regional Psychiatry Director, and site mental health leadership to increase available programming.

It was noted that inmates were generally seen on time for medication renewal. When new medications were started or changes to current medications were made, this typically resulted in the inmates being seen earlier than the standard 90 days.

In April, discharge planning information was included in all the treatment plans reviewed. Clinicians appeared to be aware of pending releases and assisted patients with preparing for release. In June, discharge planning was not accounted for in 22% of charts reviewed.

The review of sick call requests showed that responses were generally timely. Routine mental health visits for inmates identified as mental health patients occurred in a timely manner in 90% of cases reviewed. Many patients were seen more frequently when clinical symptoms indicated the need.

SCI:

A review of the treatment at SCI indicated that seven mental health groups were being offered, one for each housing unit. During the audit, the groups all focused on anger management. The Mental Health Director reported that the next round of treatment groups would focus on grief and loss or parenting issues. A review of records showed that the group notes were not always filed in the offender's chart in a timely manner.

HRYCI:

There are still significant problems with quality and quantity of services provided; requirements for frequency and type of treatment are not being met (treatment is not always individualized). Groups are attended, but a limited menu of services is being offered. There is not a proper treatment space: acoustics are poor and conditions are less therapeutic because groups are held in the lunch room. Noise from overhead announcements disrupts activities. If there is an incident in the Facility, no programming occurs because the unit is shut down. The clinician has a good relationship with inmates and there is good preparation for group sessions, but space and programming are limited.

JTVCC:

The SNU is fully staffed and there is procedure and policy in place. There are five hours of programming per day. There is now a room for the psychiatrist to see patients privately.

(38) Review of Disciplinary Charges for Mental Illness Symptoms:

DOC has implemented a policy that requires medical staff to review the medical records of all offenders who are placed in segregation. The policy requires that medical staff identify inmates placed in isolation who have a history of mental illness. Once identified, a referral is made to mental health staff. Mental health staff must perform an assessment to identify any contraindications to the placement in segregation. If any DOC or CMS staff member believes that an inmate's mental health condition is related to or may have contributed to his disciplinary charges, the inmate is referred to a mental health professional for assessment. The mental health professional provides recommendations based on that assessment to the security staff conducting the disciplinary hearing. The previous BCHS Mental Health Treatment Administrator provided training to all mental health staff at the Facilities to ensure proper compliance with this policy. Further, all Facilities have started the process of using tracking logs to ensure compliance with the policy.

BWCI:

Charts reviewed indicated that security staff is seeking input from Mental Health staff when Mental Health inmates are transferred to segregation. None of the records reviewed revealed that inmates were placed in segregation as a result of decompensation or failure to receive mental health care.

SCI:

A log of inmates moved into segregation, who were referred to Mental Health by security, is maintained by the Mental Health Director. During the audit, nine charts were reviewed of offenders who had been placed in segregation status which required mental health review. Eight of the inmates referred were seen the same day and one was seen the next day. There were no mitigating factors found in eight of the cases. In one case, however, it appeared that mental health indicated the inmate was not able to participate in the substance abuse program due to his mental condition and therefore should not have been given a sanction for his refusal to participate. It appeared from the record that he may still have been made to serve the sanction despite this information. Further discussion with the Mental Health Director revealed that the opinion of the mental health staff and psychiatrist changed after the initial recommendation. After further review, they came to the conclusion that the offender was feigning mental illness symptoms to avoid participation in the program. This information was shared with the security hearing officer. Although their clinical opinion may have played a role in the decision to require the offender to serve the sanction, the subsequent assessment and discussion were not documented.

HRYCI:

At this point, HRYCI patients with serious mental illness are reviewed by a qualified mental health clinician prior to placement in isolation to determine the extent to which the charge might have been related to the mental health condition.

JTVCC:

Currently, disciplinary charges against inmates with serious mental illness who are placed in isolation are not being reviewed by qualified mental health clinicians to determine the extent to which the charge may have been related to serious mental illness, and to determine whether an inmate's serious mental illness should be considered by JTVCC security staff as mitigating factors when punishment is imposed on inmates with serious mental illness. At this time, security staff does not send a request to metal health staff to review disciplinary charges against inmates with mental illness. However, security personnel at JTVCC stated that they will conduct a comprehensive review of the disciplinary charges process and ensure that mental health staff review the charges and provide feedback as to any mitigating factors when punishment is imposed on inmates with serious mental illness.

(39) Procedures for Mentally Ill Offenders in Isolation or Observation Status:

As noted above, a referral is made to mental health for offenders placed in isolation who are currently, or have a history of, receiving mental health treatment. For these offenders, rounds are performed three times each week by mental health staff, which exceeds the once a week requirement established in the MOA. The Facility psychiatrist is required to review documentation regarding the mental health rounds. As is discussed in ¶ 38, mental health staff communicates any concerns regarding contraindications to segregation, and custody staff is required to respond appropriately.

BWCI:

In our sample, 90% of inmates on suicide observation are seen daily for assessment by a qualified mental health professional. The psychiatrist is seeing patients on observation 3 days per week (each day he is at BWCI). In all charts reviewed, the psychiatrist saw the patient at least once prior to discharge, as required. In most cases, inmates released from suicide watch are seen by a mental health professional within 24 hours of release.

JTVCC:

JTVCC is currently not consistently involving mental health in reviewing cases of patients placed in isolation. Medical, however, does review these cases prior to placement. At this point, the issue appears to be that JTVCC does not inform mental health of imminent transfer to segregation. BCHS is working with JTVCC to have mental health informed of segregation placements at the same time medical is informed.

(40) Mental Health Service Logs and Documentation:

As noted above, the mental health clinicians at each Facility maintain a Mental Health roster listing each individual receiving mental health services, diagnosis, mental health medications and dates for upcoming mental health treatment appointments. The roster is currently accessible by all mental health employees at each Facility. Further, the roster for all Facilities is provided to the BCHS Mental Health Treatment Administrator for her review on a monthly basis.

BWCI:

The Mental Health roster is up to date and accurate at BWCI.

JTVCC:

The Mental Health roster is up to date and accurate at JTVCC.

SUICIDE PREVENTION

(41) Suicide Prevention Policy:

On November 19, 2007, DOC implemented its Suicide Prevention Policy. On May 9, 2008, DOC submitted revisions to its November 19, 2007 policy at the recommendation of the Monitoring Team. The revised policy was approved and has been implemented. The policy for all sites was approved by the Monitors/DOJ and is unchanged.

(42) Suicide Prevention Training Curriculum:

DOC worked collaboratively with the Monitoring Team Mental Health experts to draft the Suicide Prevention Training Curriculum and policy. The curriculum, at a minimum, addresses the DOC Suicide Prevention policy, the ways in which the Facility environment may contribute to suicidal behavior, potential predisposition factors to suicide, high risk suicide periods, case studies of recent suicides and serious suicide attempts, and proper use of emergency equipment. Upon approval from the DOJ, the DOC implemented its Suicide Prevention Refresher Training curriculum. The training was offered online to the security staff along with medical and mental health staff that also required the refresher training.

The curriculum was approved for all sites and has not been changed.

(43) Staff Training:

The DOC Action Plan states that Suicide Training will be provided to the entire DOC security staff by January 1, 2008. As of the date of this report, Facilities report that all security staff available (unavailable staff include those who have been out on military leave or extended medical leave) have received the required training. Courses are ongoing, and will continue to be provided to all new hires after existing staff is trained. Each Facility training coordinator maintains training records. Copies of the training records are also sent to CMS to record medical and mental health staff attendance of Suicide Prevention training at all Facilities. Additional copies of the training records are maintained at the DOC Central Administration Building by the BCHS Senior Fiscal Administrative Officer, and are available for the Monitoring Team's review.

BWCI:

In our sample, all staff members at BWCI had attended suicide training and were within the time standard for initial or refresher suicide training.

SCI:

In our sample, all staff members at SCI had attended suicide training and were within the time standard for initial or refresher suicide training.

HRYCI:

In our sample, all staff members at HRYCI had attended suicide training and were within the time standard for initial or refresher suicide training.

JTVCC:

In our sample (83 staff members), all staff members had attended suicide training and were within the time standard for initial or refresher suicide training (7 were exempt from training due to position title).

(44) Intake Screening/Assessment:

Currently, the DOC uses an intake screening that covers all of the required areas listed in the MOA. A mental health assessment is provided for those patients whose screening indicates any positive answer to the screening tool. As noted in paragraph 10, audits performed by BCHS indicate that intake screenings are performed in a timely manner as required by DOC policy.

100% of patients at all facilities are screened for mental health concerns, including suicidality.

(45) Mental Health Records:

An inmate who reports a significant medical or mental health history or recent mental health hospitalization at intake is asked to complete a release of information form. The medical and mental health staff requests the relevant medical documents from outside providers. The CMS medical records staff is responsible for forwarding the request for documents to the appropriate health care Provider(s). Once received, the records are filed with and become a part of the inmate's unified medical record. CMS is currently working to improve the process of obtaining relevant information from the outside providers.

BWCI:

Overall, mental health records were found to be poorly organized and frequently misfiled. 67% of records reviewed for patients recently on psychiatric observation had notes related to their staff filed in

different sections of the same record. One of these charts also had so many notes in the "psychiatry" section that a new section was started in a different location of the same record, with the same heading. Records from community providers appear to have been requested routinely, but are obtained about 50% of the time.

JTVCC:

Mental health records were not always filed in the mental health/psych section of the medical records. This problem was evident when reviewing the charts of inmates who required psychiatric observation. In 59% of charts of inmates who spent time under psychiatric observations, the psychiatric observation records remained in the infirmary section of the charts. In the other 41%, the psychiatric observation records were filed in the mental health/psych section of the chart. Of the charts reviewed to assess the timeliness of MARs filing, 13% of the medical records did not include May 2009 MARs. Progress notes, physician orders, and other mental health records were not always filed in a chronological order. In some cases, the medical staff noted that pharmacies and community providers did not confirm an inmate's mental health history or verify psychotropic medications. Not all charts, however, included the inmate's consent to release such information or evidence that a written request was faxed to the community provider.

(46) Identification of Offenders at Risk of Suicide & (47) Suicide Risk Assessment:

When an inmate is identified as at risk for suicide, the inmate is kept under constant supervision, mental health/medical is contacted immediately and an order is obtained to place the inmate on psychiatric observation. The inmate is also assessed by a qualified mental health professional as soon as possible and no later than twenty-four hours after the risk has been identified. Due to the seriousness of risk of suicide, CMS has implemented a policy that requires that all offenders who are placed on suicide precautions be immediately placed on a high level of observation. Only after a direct face-to-face interview with a mental health clinician or psychiatrist and appropriate review of the offender's mental health history, will the clinical determination to downgrade the level of suicide precaution status be authorized.

BWCI:

The psychiatrist at BWCI makes rounds in the infirmary 3 days per week. Also rounding in the infirmary are the Clinical Supervisor and site Director. 22% of records reviewed for psychiatric observation did not have discharge orders in the record.

SCI:

At SCI, the psychiatrist currently makes rounds in the Infirmary four days a week. Also rounding in the Infirmary is a PhD staff member who is licensed at the master's level, the Site Director, and a Licensed Clinical Social Worker. An audit performed by the DOC Mental Health Treatment Administrator indicated that assessments were being performed timely and generally completed by the psychiatrist. Further, when admissions occurred on the weekends, the offender was seen by another member of the mental health staff and the assessment was completed by the psychiatrist upon his return on Monday. A review of the assessments indicated that they were complete and appropriate.

HRYCI:

There is not daily psychiatric coverage in the Infirmary at HRYCI; when there is coverage, there is little continuity as it is a different provide each time. The pharmacy room is now an interview room but there is inadequate privacy.

JTVCC:

The psychiatrist makes rounds in the infirmary 4 days per week. Also rounding in the infirmary is a licensed psychologist one day a week. On weekends, mental health clinicians round the infirmary. On 7/22/09, 3 patients were under psychiatric observation when a BCHS Monitor toured the infirmary and all 3 patients were dressed in suicide prevention gowns. Charts of inmates who were placed on psychiatric observations over the last 2 months were reviewed. 88% of patients received the required daily and post discharge visits. One daily visit was missing from one chart and 2 post discharge visits were missing from another chart. In two cases, treatment plans were not developed prior to releasing the patients from the infirmary.

(48) Communication:

All steps taken relating to inmate suicide precautions are documented by the CMS and DOC staff responsible for carrying out those steps, and become part of the inmate's unified medical record. Multi-disciplinary team meetings are also conducted on a weekly basis regarding the inmate's stability and their status on suicide precautions. Offenders are not downgraded or discharged from suicide precautions until the responsible medical and mental health care staff has thoroughly reviewed the inmate's health care record. Mental health staff is instructed to discuss patient progress with custody staff when making decisions regarding downgrade or discharge of observation status.

BWCI:

At last report, mental health staff was meeting with the DOC Treatment/Counseling staff.

JTVCC:

At last report, mental health staff was meeting with the DOC Treatment/Counseling staff.

(49) Housing:

Pursuant to DOC policy, all cells used to house offenders on suicide watch are visible to correctional staff and steps have been taken to improve suicide resistance in cells used for this purpose. For example, breakaway sprinkler heads have been installed in cells used for suicide watch. Mental Health staff determines the level of restriction (what items an inmate may have in their cell) that is appropriate for the inmate based on clinical judgment.

BWCI:

Unchanged from last reporting period.

SCI:

Space remains limited in the Infirmary, and therefore, offenders on suicide watch are being held on overflow housing. A review of the logs, however, indicates that the required level of monitoring of these offenders is occurring as required by DOC policy standards. As noted earlier, expansion plans are ongoing and will include additional appropriate Infirmary cells.

HRYCI:

Suicide watch cells are appropriate and within standard. There is one cell where the floor toilet has been converted to a stainless steel suicide-resistant toilet.

JTVCC: Suicide cells are appropriate and within standard. There have been no changes since the last report.

(50) Observation:

At the highest level of psychiatric observation, offenders are observed on a constant basis. Offenders on all levels of psychiatric observation will also be observed on a constant basis while bathing and shaving. All other offenders on observation are monitored at least every fifteen minutes by correctional staff and during each shift by medical staff. A physician performs a physical assessment whenever an inmate is

placed on observation. Further, mental health staff assesses and interacts with all offenders on psychiatric observation status on a daily basis.

Suicide observation policy is in place at all sites and offenders are observed per policy.

(51) "Step-Down Observation":

DOC policies and procedures require step-down levels of observation be used when offenders are released from suicide precautions. All offenders on psychiatric observation can only be downgraded or removed from observation status with an order from a licensed psychologist or psychiatrist. Follow-up assessments are conducted initially within twenty-four hours following discharge from suicide precautions and subsequently as clinically indicated on the individual treatment plan. The DOC-CMS Audit Tool is used to ensure compliance of appropriate suicide observation and follow up treatment on all offenders who were on observation status for the quarter prior to the audit.

BWCI:

Step down observation was generally conducted appropriately in records reviewed.

SCI:

An audit of charts indicated that offenders released from observation status, were followed timely and appropriately. Further, many were followed more frequently than what is required by DOC policy and the psychiatrist continued to closely monitor the offender.

HRYCI:

HRYCI is doing well with post discharge follow up, but improvement is needed with 7 and 21 day follow-up. There continue to be problems with appropriately triaging patients for PCO status, with some being inappropriately triaged at too high or too low a level. This is particularly a problem overnight.

JTVCC:

It was evident from reviewing the medical records of 16 released psychiatric observation patients that the psychiatrist and mental health clinicians are utilizing the step-down observation policy. The review revealed that patients were released gradually from the more restrictive levels of observations to less restrictive levels of observations prior to discharging them from suicide precautions.

(52) Intervention:

This topic is covered under the DOC's response to First Aid/CPR training and Suicide Prevention Training (¶ 28).

(53) Mortality and Morbidity Review:

Current policy requires a mortality and morbidity (M and M) review to be accomplished in the event of a suicide, death or a serious suicide attempt. Pursuant to DOC policy, the review is conducted at the Facility within 30 days of the event. At minimum, the Warden (or designee), DOC Medical Director, CMS Regional Medical Director, HSA, DON and site Medical Director will attend the review. The Office of Medical Examiner conducts a Post Mortem (autopsy) on any offender death. The report, if available, is provided for the review. A member of the Medical Society of Delaware attends the review, and submits their report to the review board to consider in its findings. Mortality and morbidity reports are completed as indicated, are maintained at the DOC Central Administration Building, and are available for review by the Monitoring Team. BCHS conducts and coordinates the reports generated by the M and M review. The process is being refined to better target those issues that may be systemic in nature in order to address any deficiencies found.

BWCI:

M&Ms are occurring per policy.

JTVCC:

M&Ms are occurring per policy.

QUALITY ASSURANCE

(54) Policies and Procedures and (55) Corrective Action Plans:

DOC policies address a number of quality assurance processes. The Quality Improvement Program is being developed by the BCHS Quality Assurance Administrator. The Quality Assurance Administrator is working with each Facility HSA and Regional Manager to implement and maintain a Quality Improvement Program. Each site has implemented a Facility Quality Improvement Committee. The Facility holds monthly meetings to identify, analyze and correct problems that may impede the quality of inmate health care. Each Facility has identified committee members and assigned specific teams to conduct CQI studies in their respective areas. The Facility Committee members also address any areas requiring corrective action as a result of the DOC quarterly contractual audit and internal audits. The Facility Quality Improvement Committee will meet on a monthly basis to discuss its findings and issue corrective action plans when appropriate. Minutes are recorded at every meeting. Meeting minutes and CQI results are shared at monthly staff meetings, site MAC meetings, Quarterly Statewide level CQI meetings, and DOC Statewide Quality Committee.

The Statewide Quality Improvement Committee reviews implementation, maintenance, and monitoring of quality improvement programs at the Facilities. The QI Committee meets on a quarterly basis, reviews all minutes and quarterly reports submitted by the Facility QI committees, and makes recommendations to the Commissioner of Correction as necessary. Further, an annual report will be generated to the Commissioner summarizing areas that have been improved in the past year and those which need improvement. DOC and CMS have formed the committees at the Facility and State levels and are continuing with the QI process. Adjustments and enhancements to the QI process at each Facility are ongoing. With the addition of the BCHS Quality Assurance Administrator and Medical Director, DOC will begin to focus on various areas of the QI process and implementation of action plans in addition to the process being performed by CMS. The previous Quality Assurance Administrator compiled the contractual audit tools; as discussed above, these are being incorporated with comprehensive QA tools to address each area of the MOA. The finalized QA tools are to comply with DOC Policies as well as NCCHC standards. The Monitoring Team has been provided copies of the contractual audit tools for solicitation of their suggestions. Copies of the Facility QI Committee minutes are maintained at the CMS regional office and statewide QI Committee minutes are maintained at the BCHS offices. Both sets of documents are available for review at the Monitoring Team's request.

BCHS currently uses the FADE Quality Improvement Model for CQI, a methodology which **f**ocuses, **a**nalyzes, **d**evelops, **e**xecutes and **e**valuates selected processes in an effort to continuously improve quality of services. BCHS will use the FADE Model to define and fix problems in health care services and delivery processes at individual Facilities and system-wide.

CONCLUSION

DOC continues to develop and build the infrastructure necessary to assure that health care services in the Delaware correctional system meet or exceed constitutional standards, thus satisfying not only the State's own requirements, but also the requirements of the federal laws enforced by the DOJ. By reorganizing the Office of Healthcare Services into a Bureau of Correctional Healthcare Services and by funding and supporting the numerous compliance efforts summarized in this Report, the State has demonstrated that:

- the State of Delaware and DOC are committed to maintaining the improvements made in correctional health care services;
- substantial resources and time have been and continue to be devoted to developing a multidisciplinary team of professionals to oversee the provision of offender health care; and
- DOC is committed to changing its organizational culture to facilitate further improvements in the delivery of correctional health care services.

BWCI and SCI exemplify the results of DOC efforts to comply with the MOA and to provide offenders care required under the Constitution. While improvement is needed in some areas at these two sites, the overwhelming trend is toward substantial compliance with the standards set forth in the MOA (many of which undeniably exceed the baseline required under the Constitution). JTVCC and HYRCI still have much room for improvement, although new additions to mental health staff at JTVCC are promising and improvements to services are expected.

The challenge now is to allocate DOC resources in a manner that produces the maximum possible value from these investments. The benefits of the monitoring and technical assistance provided under the MOA have been largely realized, and are now outweighed by the time and resources consumed. The manpower and capital required under the MOA are great, and meeting those requirements interferes with the ability of BCHS to perform its primary mission. Those resources would now be better spent on developing and sustaining improvements.

DOC believes that federal oversight, paired with a transparent and cooperative effort by the State, worked in Delaware for the benefit of the citizens both governments serve, and can be viewed as a model for other correctional systems. The time has come, however, to release the State to move forward with its own monitoring, to allow DOC to focus on improving quality of care, rather than responding to the demands of frequent and time-consuming outside audits, and to further develop its own capacity to deliver appropriate health care services in the Delaware correctional system.